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Transactions of the New Hampshire Medical Society ...

New-Hampshire Medical Society

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TRANSACTIONS

OF THE

NEW HAMPSHIRE MEDICAL SOCIETY

Compliments of the

New Hampshire Medical Society

D. E. Sullivan, M. D., Secretary

Concord, N. H.

CONCORD, N. H.:
IRA C. EVANS CO., PRINTERS.
1906.

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1791 1906

TRANSACTIONS

OF THE

NEW HAMPSHIRE MEDICAL SOCIETY

AT THE

ONE HUNDRED AND FIFTEENTH ANNIVERSARY

HELD AT

CONCORD, MAY 17 AND 18, 1906.

CONCORD, N. H.:
IRA C. EVANS CO., PRINTERS.
1906.

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NEW HAMPSHIRE MEDICAL SOCIETY.

OFFICERS FOR 1906–1907.

PRESIDENT.

IRA J. PROUTY, M. D., Keene.

VICE-PRESIDENT.

JOHN H. NEAL, M. D., Rochester.

SECRETARY.

D. E. SULLIVAN, M. D., Concord, term expires 1910.

TREASURER.

D. M. CURRIER, M. D., Newport, term expires 1910.

COUNCILORS.

For One Year.

Coös County—Wm. H. LEITH, M. D.
Carroll County—JOHN H. SHEDD, M. D.

For Two Years.

Belknap County—A. H. HARRIMAN, M. D.
Grafton County—M. S. WOODMAN, M. D.

For Three Years.

Cheshire County—M. T. STONE, M. D.
Sullivan County—H. A. HANNAFORD, M. D.

For Four Years.

Merrimack County—CHARLES R. WALKER, M. D.
Hillsborough County—JAMES T. GREELEY, M. D.

For Five Years.

Rockingham County—A. W. MITCHELL, M. D.
Strafford County—FORREST L. KEAY, M. D.

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HOUSE OF DELEGATES.

Rockingham County—J. W. PARSONS, M. D., Portsmouth.
J. J. BERRY, M. D., Portsmouth.

Belknap County—GEORGE H. SALTMARSH, M. D., Lakeport.
C. S. LITTLE, M. D., Laconia.

Strafford County—A. N. SMITH, M. D., Dover.
L. W. FLANDERS, M. D., Dover.

Carroll County—W. S. DAVIS, M. D., Sanbornville.
N. H. SCOTT, M. D., Wolfeborough.

Merrimack County—E. E. GRAVES, M. D., Penacook.
*D. E. SULLIVAN, M. D., Concord.

Hillsborough County—GEORGE D. TOWNE, M. D., Manchester.
F. E. KITTREDGE, M. D., Nashua.
E. WASON, M. D., Milford.

Cheshire County—M. T. STONE, M. D., Troy.
J. A. CRAIG, M. D., Westmoreland.

Sullivan County—H. A. HANNAFORD, M. D., Newport.
F. P. CLAGGETT, M. D., Newport.

Grafton County—WM. T. SMITH, M. D., Hanover.
H. L. JOHNSON, M. D., Franconia.

Coös County—EZRA MITCHELL, M. D., Lancaster.
J. J. COBB, M. D., Berlin.

BOARD OF MEDICAL EXAMINERS FOR THE SOCIETY.

GEORGE COOK, M. D., Concord, term expires 1907.

GEORGE H. SHEDD, M. D., North Conway, term expires 1908.

*Resigned.

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JOHN F. ROBINSON, M. D., Manchester, term expires 1909.
JAMES T. GREELEY, M. D., Nashua, term expires 1910.
ARTHUR C. HEFFENGER, M. D., Portsmouth, term expires 1911.
President—GEORGE COOK, M. D., Concord.
Secretary—JAMES T. GREELEY, M. D., Nashua.

TRUSTEES.

JOHN W. PARSONS, M. D., Portsmouth, for one year.
WILLIAM T. SMITH, M. D., Hanover, for two years.
S. M. DINSMOOR, M. D., Keene, for three years.

DELEGATES TO DARTMOUTH MEDICAL COLLEGE.

W. H. LEITH, M. D., Lancaster.
W. J. BEATTIE, M. D., Littleton.

DELEGATE TO THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION.

JOHN M. GILE, M. D., Hanover.

ALTERNATE.

WM. T. SMITH, M. D., Hanover.

COMMITTEE ON CORRESPONDENCE AND AFFILIATION.

IRA J. PROUTY, M. D., Keene.
GEORGE COOK, M. D., Concord.
CHARLES R. WALKER, M. D., Concord.

NECROLOGIST.

E. E. GRAVES, M. D., Penacook.

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STANDING COMMITTEES.

Committee on Scientific Work.

D. E. SULLIVAN, M. D., Concord.
E. E. GRAVES, M. D., Penacook.
GEORGE COOK, M. D., Concord.

Committee on Public Policy and Legislation.

GEORGE COOK, M. D., Concord.
J. F. ROBINSON, M. D., Manchester.
JAMES T. GREELEY, M. D., Nashua.
President, *ex-officio.*
Secretary, *ex-officio.*

Committee on Publication.

D. E. SULLIVAN, M. D., Secretary.
IRA J. PROUTY, M. D., President.
D. M. CURRIER, M. D., Treasurer.

Committee of Arrangements.

F. R. CUMMINGS, M. D., Concord.
C. H. COOK, M. D., Concord.
A. F. SUMNER, M. D., Concord.
E. A. CLARK, M. D., Concord.
R. J. GRAVES, M. D., Concord.
C. H. DOLLOFF, M. D., Concord.
R. E. GALLINGER, M. D., Concord.

The next annual meeting of the New Hampshire Medical Society will be held in Concord, May 16 and 17, 1907.

All communications intended for the Society should be addressed to the Secretary, D. E. Sullivan, M. D., Concord.

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NEW HAMPSHIRE MEDICAL SOCIETY.

PROCEEDINGS

OF THE

ONE HUNDRED AND FIFTEENTH ANNIVERSARY.

MORNING SESSION, THURSDAY, MAY 17, 1906.

The members of the New Hampshire Medical Society convened in Memorial Hall, Concord, at 11 o'clock.

The President, F. A. Stillings, M. D., of Concord, called the meeting to order and introduced the Chaplain, The Rt. Rev. Edward M. Parker, D. D., who invoked Divine blessing.

INVOCATION BY THE RT. REV. EDWARD M. PARKER, D. D., CONCORD.

O Lord, Thou hast searched me out, and known me, Thou knowest my down-sitting, and mine up-rising; Thou understandest my thoughts long before. Thou art about my path, and about my bed, and spiest out all my ways. Thou hast fashioned me behind and before, and laid Thine hand upon me. Yea, the darkness is no darkness with Thee, but the night is as clear as the day, the darkness and light to Thee are both alike. For my reins are thine, Thou hast covered me in my mother's womb. I will give thanks unto Thee, for I am fearfully and wonderfully made, marvellous are Thy works, and that my soul knoweth right well. My bones are not hid from Thee, though I be made secretly, and fashioned beneath in the earth. Thine eyes did see my substance, yet

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being imperfect, and in Thy book were all my members written; which day by day were fashioned; when as yet there was none of them.

We pray Thee, Lord of heaven and earth, Creator of the world and Saviour of men, to guide and direct the work of this association. All power and wisdom come from Thee. Thou willest that men should be the instruments of Thy power and love, and Thou directest us to search into the hidden things of Thy laws.

That Thou wilt deepen our knowledge and increase our wisdom, we beseech Thee to hear us, good Lord.

That Thou wilt grant us power to relieve the suffering and to cure disease, we beseech Thee to hear us, good Lord.

That Thou wilt bless all efforts to find out the hidden things of Thy eternal laws, we beseech Thee to hear us, good Lord.

That Thou wilt enable us to care for all sick persons, for women in peril of child-birth, for young children, for the aged, for the insane, and for the dying, we beseech Thee to hear us, good Lord.

That Thou wilt give us power to use our opportunities to strengthen such as do stand, and to comfort and help the weak-hearted, and to raise up those who fall, and to beat down evil under our feet, we beseech Thee to hear us, good Lord.

That Thou wilt enable us to defend, and to aid the fatherless children and widows, and all who are desolate and oppressed, we beseech Thee to hear us, good Lord.

That it may please Thee to give us true repentance for all our faults, to forgive us all our sins, negligences, and ignorances, and to endue us with the grace of Thy Holy Spirit, to amend our lives according to Thy holy Word, we beseech Thee to hear us, good Lord.

O God, the strength of all those who put their trust in Thee, mercifully accept our prayers; and because, through the weakness of our mortal nature, we can do no good thing without Thee, grant us the help of Thy grace, that in keeping

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Thy commandments and doing the work which Thou hast given us, we may please Thee, both in will and deed; through Jesus Christ our Lord.

Our Father, which art in heaven, Hallowed be Thy name. Thy kingdom come. Thy will be done in earth, as it is in heaven. Give us this day our daily bread. And forgive us our debts, as we forgive our debtors. And lead us not into temptation, but deliver us from evil: For Thine is the kingdom, and the power, and the glory, forever. Amen.

The President then called for the reading of the records of the last meeting, when, on motion of Dr. Cook, it was voted to dispense with the reading, the records having been printed and distributed.

Report of the Committee of Arrangements, by the chairman, L. A. Sanders, M. D., Concord:

The Committee of Arrangements met at the office of the Secretary, March 15, 1906. The following sub-committees were appointed to arrange for the annual meeting:

Transportation—Dr. A. F. Sumner, Concord.
Hall—Dr. L. A. Sanders, "
Exhibits—Dr. F. R. Cummings, "
Dr. C. H. Cook, "
Banquet—Dr. L. A. Sanders, "
Dr. A. F. Sumner, "
Dr. C. H. Dolloff, "
Dr. R. J. Graves, "
Dr. George Cook, "
Registration—Dr. R. J. Graves, "
Dr. C. H. Dolloff, "
Chaplain—Dr. L. A. Sanders, "
Music—Dr. A. F. Sumner, "
Dr. C. H. Dolloff, "

In compliance with Section 4, chapter 1 of the by-laws, Dr. George Cook was appointed a committee to procure badges.

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The Boston & Maine Railroad very kindly granted the usual reduction in rates.

This hall was engaged for this meeting soon after our last annual meeting in order to secure it.

SECT. 4. Each member in attendance at the annual session shall enter his name on the registration book, indicating the county society of which he is a member. When his right to membership has been verified by reference to the roster of his Society, he shall receive a badge which shall be evidence of his right to all the privileges of membership at that session. No member or delegate shall take part in any of the proceedings of an annual session until he has complied with the provision of this section.

Under the constitution, registration being required, we have arranged for the members to pass in through the entry and register before entering the hall.

The badge provided by the Society is the annual badge. The little button is so designed that the green and white are the colors of Dartmouth College and the center is the color of the American Medical Association. This is the gift of our President, Dr. Stillings, and I trust you will see to it that it is made the permanent badge of the Association.

The usual display of exhibits is arranged down stairs and it is desired that as many as can will go through the room and take recognition of this feature.

The annual banquet will be held this evening at the Eagle Hotel, at 7.30, and it is hoped that all who can will attend and assist in making this feature of our meeting as successful as it has always been in the past. It is desired that you purchase your tickets early in the day, as it is necessary to know how many to provide for. Dr. Sumner will have charge of the tickets which will be $1, the same as heretofore.

We feel that we were fortunate in being able to secure as our Chaplain this year, the Rt. Rev. Dr. Parker.

I have taken the matter up with each of the hospitals, the Womans' Memorial Hospital, the Margaret Pillsbury General Hospital, and the State Hospital, and each of them seemed

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very anxious that any one attending from out of town, delegates or visiting guests, who would like to visit these hospitals should do so. They will show you every courtesy and it is desired as many as can will take advantage of this privilege at any or all of the above institutions.

Immediately following the President's address the House of Delegates will convene up stairs.

The President then appointed the following:

COMMITTEE ON RECEPTION OF DELEGATES.

A. C. HEFFENGER, M. D., Portsmouth.
R. J. GRAVES, M. D., Concord.
GEORGE C. WILKINS, M. D., Manchester.

The Committee on Reception of Delegates subsequently introduced to the Society, Robert H. McConnell, M. D., of New York; Arthur W. Fairbanks, M. D., of Boston; and F. Thomas Kidder, M. D., of Woodstock, Vt. Dr. Kidder responded as follows:

"I am not prepared to make a speech. I will simply say that I am very glad to bring you the greetings of the Vermont Medical Society and be with you at this meeting."

The President then read the annual address.

Immediately after, the House of Delegates met in an upper hall for organization and business and the scientific part of the meeting was presided over by the Vice-President, Ira J. Prouty, M. D., of Keene.

The first on the programme was a paper entitled "A Rare Case of Convulsions," by Ralph E. Gallinger, M. D., Concord. This paper was discussed by Russell Wilkins, M. D., of Concord.

L. M. Keene, M. D., of Kittery Point, Me., read a paper on "Hysteria and Neurasthenia," which was discussed by J. H. Neal, M. D., Rochester, and Dr. Guptill, of Raymond.

"Placenta Previa" was the title of a paper presented by Chancey Adams, M. D., of Concord. This was discussed

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by Dr. C. R. Walker, of Concord, and Dr. T. M. Togus, of Hooksett.

On motion of Dr. Walker, of Concord, the Society adjourned until 2.30 P. M.

AFTERNOON SESSION—MAY 17, 1906.

The meeting was called to order at 2.30 P. M.

The reading of papers was resumed, and F. Von Tobel, M. D., of Lebanon, presented a paper on "Cerebro-Spinal Meningitis." The discussion on this paper was opened by H. A. Kingsford, M. D., Hanover, continued by Dr. J. H. Gleason, of Manchester, and Dr. McConnell, of New York.

C. F. Ober, M. D., of Manchester, read a paper on "Diphtheria." Dr. Wilkins not being present the paper was open to discussion which was freely participated in by Dr. McConnell, of New York; Dr. O. C. Young, of Charlestown; Dr. Kingsford, of Hanover; Dr. Von Tobel, of Lebanon; Dr. Kidder, of Vermont; Dr. Brown, of Manchester; Dr. Togus, of Hooksett; and closed by Dr. Ober.

"Unusual Complications of Typhoid Fever, with Report of Cases," by R. G. Blanchard, M. D., of Dover, was discussed by Dr. A. Noel Smith, of Dover, and Dr. Anthoine, of Nashua.

A. M. Fernald, M. D., of Sutton, presented a paper entitled "Atrophy of the Intestines." This was discussed by Dr. Sanders, of Concord, and Dr. Mitchell, of Epping.

"Tuberculosis of the Urinary Tract," by John W. Coolidge, M. D., was read by title and referred to the Committee on Publication, the writer not being present.

A paper entitled "Three Cases of Psittacosis," by N. H. Scott, M. D., of Wolfeborough, was read by Dr. George Cook, the author being unable to be present.

The following papers were read by title and referred to the Committee on Publication, the authors not being present: "Lobar Pneumonia," C. E. Hight, M. D., Milan; "Backache in Women," by T. W. Luce, M. D., Portsmouth; "Treatment of Strangulated Hernia," by E. F. McQuesten, M. D., Nashua.

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Volunteer reports of cases were given by Dr. Togus and Dr. Day just before the close of the session.

Meeting then adjourned for the Anniversary dinner at 7.30 this evening.

MORNING SESSION—FRIDAY, MAY 18, 1906.

The meeting was called to order at 8.30 A. M., by the Vice-President, Dr. Prouty, and the scientific programme was taken up.

The first was a paper on "Generalized Cancer of the Peritoneum," by J. M. Gile, M. D., Hanover, which was discussed by Dr. Kingsford, of Hanover, and Dr. Gleason, of Manchester.

"Laceration of the Perineum and its Treatment," by W. J. Beattie, M. D., Littleton; this was discussed by Dr. E. O. Crossman, Littleton, and Dr. Gile, of Hanover.

"Cæsarean Section, with Report of Case," by James S. Brown, M. D., Manchester. Discussion on this paper was opened by Dr. C. W. Milliken, of Manchester; Dr. Gile, of Hanover; Dr. R. J. Graves, of Concord; Dr. I. G. Anthoine, of Nashua; Dr. Beaton, of Franklin; Dr. Sanders, of Concord; and closed by Dr. Brown.

"The Physician's Duty to the People," by A. E. Grant, M. D., Durham. The discussion on this paper was opened by Dr. Fairbanks, of Boston.

Arthur W. Fairbanks, M. D., of Boston, gave "The Modern Conception of the Symptom-Complex, hitherto known as Friedreich's Disease," which was illustrated by photographs.

Robert H. McConnell, M. D., attending physician to the French Hospital, New York, gave a paper entitled "Enuresis."

On motion of Dr. Sanders, a vote of thanks of the Society was extended to Dr. Fairbanks and Dr. McConnell for the papers presented.

Report of the House of Delegates.

Trustees' report was read by Dr. Smith.

Installation of new officers.

Meeting adjourned.

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NEW HAMPSHIRE MEDICAL SOCIETY.

THE HOUSE OF DELEGATES

ASSEMBLED AT

CONCORD, N. H., May 17, 1906.

The meeting was called to order by its President, Dr. Ferdinand A. Stillings, of Concord.

The following members being present a quorum was declared:

Rockingham County—J. W. Parsons, M. D., Portsmouth.

Belknap County and Winnepesaukee Academy of Medicine—George H. Saltmarsh, M. D., Lakeport.

Strafford County and District Medical Society—A. N. Smith, M. D., Dover; L. W. Flanders, M. D., Dover.

Carroll County—No representation.

Merrimack County, Centre District—E. E. Graves, M. D., Penacook; D. E. Sullivan, M. D., Concord.

Hillsborough County—George D. Towne, M. D., Manchester; F. E. Kittredge, M. D., Nashua; E. Wason, M. D., Milford.

Cheshire County—M. T. Stone, M. D., Troy.

Sullivan County—H. A. Hannaford, M. D., Newport.

Grafton County—W. T. Smith, M. D., Hanover; H. L. Johnson, M. D., Franconia.

Coös County—Ezra Mitchell, M. D., Lancaster.

The minutes of the last meeting were read by the Secretary, Dr. Granville P. Conn, and it was voted to accept the report.

Voted, That Dr. E. E. Graves and Dr. George Cook be appointed members of the Scientific Committee, and also that they serve for the ensuing year.

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Voted, that the Scientific Committee be instructed to prepare a programme consisting of not more than twelve papers for 1907 and that two members be appointed to discuss each paper.

Dr. George Cook, of Concord, Dr. J. F. Robinson, of Manchester, and Dr. James T. Greeley, of Nashua, were nominated as members of the Committee on Public Policy and Legislation; and it was voted that they be appointed.

Voted, That the President, Secretary and Treasurer be appointed members of the Committee on Publication.

The following persons were appointed by the chair as members of the Nominating Committee:

Rockingham County	—	Dr. J. W. PARSONS.
Strafford	"	Dr. A. N. SMITH.
Carroll	"	Dr. W. S. DAVIS.
Merrimack	"	Dr. E. E. GRAVES.
Hillsborough	"	Dr. E. WASON.
Sullivan	"	Dr. H. A. HANNAFORD.
Grafton	"	Dr. W. T. SMITH.
Coös	"	Dr. EZRA MITCHELL.
Belknap	"	Dr. G. H. SALTMARSH.
Cheshire	"	Dr. M. T. STONE.

It was voted that the names mentioned be accepted.

Voted, That Dr. Ira J. Prouty, Dr. George Cook and Dr. Charles R. Walker be appointed members of the Committee on Correspondence and Affiliation.

The Secretary read his special report as follows:

"Our reconstructive process, as published in our transactions of the State Society, requires that some time during the meetings the Secretary shall make a report. Therefore, your Secretary most respectfully reports that he has endeavored to do his duty during the past year, and at the same time would impress upon the minds of the House of Delegates that the New Hampshire Medical Society, in consequence of the reorganization required by the American

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Medical Association, of which delegates from our Society were active in its formation, have always had a voice in its great work since that occasion, with the work which the American Medical Association has accomplished. Therefore, to-day, we are responsible to a degree for the position which the American Medical Association holds in the world's medical congress. The medical profession in New Hampshire look back with pride upon our work and the executive ability which has been displayed by the profession in the old granite state. We were among the first to establish a state society and also a medical school which has ever been well supported by those in practice in the state, and even after leaving the state many have kept up their affiliation.

"One of the important things connected with any society is the funds necessary to defray its expenses. You will find on pages 3, 10, 11, 13 and 14, paragraphs which refer to this matter. I do not think it is necessary to say to any of you that the expenses of our Society will be considerably increased. Whether they will go beyond the annual dues, I cannot say; they are liable to for a year or two, until we can get settled down upon a method of working that will be upon an economical basis. At the same time we have in our treasury sufficient funds so that we need not, I think, make any additional dues for each member at the present time. As you will notice, it is within the province of the House of Delegates or a sub-committee on appropriations to make the assessment and direct the Treasurer to collect the same. Section 3, chapter 6, page 8, says: 'The Treasurer shall give bond for the trust reposed in him whenever the House of Delegates shall deem it requisite. . . . . He shall pay money out of the treasury only on a written order of the President, countersigned by the Secretary; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings and of the state of the funds in his hands, and perform such other duties as may be assigned to him.'

"The requiring of a bond from the Treasurer may be easily carried out by a committee of the House of Delegates

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getting some insurance company to give a bond and the Society, on the approval of the President, paying for the same. I do not think that at present any person should be required to give bonds and pay for the same out of his own pocket upon such salaries as have been paid for the past few years.

"I can only say that a certain amount of clerical labor is required which never yet has been made necessary."

On motion of Dr. D. E. Sullivan, it was voted that a committee of two be appointed by the chair to prepare charters for each of the county societies and be warranted to draw on the Treasurer for any expense that may be incurred. The chair appointed the President and Secretary to prepare the charters.

Voted, That the matter of Memorials and Resolutions be taken up on Friday, May 18, 1906.

Voted, That the report of the approval of proceedings of meetings be made on Friday, May 18, 1906, by the Secretary.

Voted, That the matter of county dispensations for members be passed over until a report is received from the Council.

On motion of Dr. Smith, it was voted that the dues for the ensuing year remain the same as last year, and in accordance with the amendment thereto by Dr. Conn, it was voted that if there are not sufficient funds to meet the expenses of the ensuing year, the President may draw on the funds already existing.

On motion of Dr. Saltmarsh it was voted that the next meeting of the Society be held in Concord, on the third Thursday and Friday of May, 1907.

Voted, That the Committee of Arrangements for the next meeting of the New Hampshire Medical Society be referred to the Merrimack County Society to take charge of the same and select the Committee of Arrangements.

On motion of Dr. Smith, it was voted that the Secretary notify the Merrimack County Society of the action taken.

On motion of Dr. Smith, it was voted that the Secretary be instructed to notify the county societies that the House of Delegates recommend that they appoint one new delegate each year.

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REPORT FROM THE COUNCIL.

The following names are recommended for admission to the New Hampshire Medical Society:

Lewis C. Aldrich, M. D., Whitefield. Member, Coös County Medical Society.

George H. Morrison, M. D., Whitefield. Member, Coös County Medical Society.

Elmer H. Carlton, M. D., Hanover. Member, Grafton County Medical Society.

George Haven Clarke, M. D., Concord. Member, Merrimack County Medical Society.

Clarence E. Butterfield, M. D., Suncook. Member, Merrimack County Medical Society.

Frank Birck Easton, M. D., Laconia. Member, Belknap County and Winnepesaukee Academy of Medicine.

John Calvin Huckins, M. D., Ashland. Member, Belknap County and Winnepesaukee Academy of Medicine.

Elmer E. Ladd, M. D., West Rumney. Member, Belknap County and Winnepesaukee Academy of Medicine.

Alfred Henry Childs, M. D., Dublin. Member, Cheshire County Medical Society.

Edmund Gerrish Dearborn, M. D., Keene. Member, Cheshire County Medical Society.

Arthur A. Pratte, M. D., Keene. Member, Cheshire County Medical Society.

Edward A. Tracy, M. D., Keene. Member, Cheshire County Medical Society.

B. Frank Horne, M. D., Conway. Member, Carroll County Medical Society.

Leon Joseph Lacasse, M. D., Manchester. Member, Hillsborough County Medical Society.

Joseph W. Finerty, M. D., Milford. Member, Hillsborough County Medical Society.

W. H. A. Lyons, M. D., Manchester. (Reinstated). Member, Hillsborough County Medical Society.

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Gustave Lafontaine, M. D., Manchester. Member, Hillsborough County Medical Society.

Wellington A. Thompson, M. D., Manchester. Member, Hillsborough County Medical Society.

Hannibal P. Wheatley, M. D., Farmington. Member, Strafford County Medical Society.

F. H. Lovejoy, M. D., Milford. Member, Hillsborough County Medical Society.

Voted, That the report from the Council as to new members be laid on the table until complete.

It was voted that it was the sense of the House of Delegates that it still continue the office of trustees and elect them as formerly.

On motion, it was voted that the Council be notified that it is the sense of the House of Delegates that Dr. E. J. Delaney, expelled from the Merrimack County Medical Society for doing contract work in violation of the action of last year, be expelled from the New Hampshire Medical Society.

The motion was made by Dr. Smith that on and after January 1, 1906, the word "organization" in the resolution passed last year, shall be construed to mean any town, city, county, state, or any other organization or corporation, and it was voted that the matter be referred to the Council.

The Council reported their interpretation of "contract physician" as follows:

"It is resolved that the sense of the Council is that the word 'contract physician' shall be interpreted to apply to those who render professional services to any club, lodge, society, or organization of like nature, at less than the regular rates of the locality."

Voted, That Dr. George W. B. Williamson, of Portland, Me., be made an honorary member of the Society.

Voted, That Dr. F. W. Spaulding, of Clifton Springs, N. Y., be placed on the retired list of the Society.

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The Treasurer reported that Dr. George E. Goodwin, of North Andover, Mass., and Dr. Frank B. Worthen, of Hinsdale, were three years in arrears, and it was voted to drop their names from the rolls.

The Treasurer reported that Dr. John S. Meserve, of Norwood, Ohio, had sent $1 on account, and it was voted that if the balance due the Society was not forthcoming before the list is printed, his name be dropped from the rolls.

Dr. Gleason made the following statement:

"The law requires that every physician dispensing whiskey unchanged to a patient shall be liable to pay the United States revenue tax of $25, to take out a revenue stamp, and hang the same in a prominent place in his office. This act consequently brands such a physician as a common seller. It is a fact that considering this, every country physician carrying a bottle of whiskey in his grip, and giving from the same to a patient, is under this law a common seller, liable to fine and imprisonment. The commissioners interpret this law that he is liable, although the patient may actually need this as a medicinal remedy."

It was voted that this matter, if presented in writing and in proper form, be referred to the Committee on Legislation.

Voted, That the button which was presented to the members by Dr. F. A. Stillings, be made the permanent badge of the Society.

Voted, That the report of the Council in regard to contract work be referred back to that body for further consideration.

Voted, To adjourn to 8.30 A. M., Friday, May 18, 1906.

Adjourned.

CONCORD, N. H., May 18, 1906.

The resignation of the Secretary, G. P. Conn, M. D., having been received by the House of Delegates, it was voted to accept the same.

H. L. Johnson, M. D., moved that in view of the retirement of G. P. Conn, M. D., as Secretary, that a resolution thanking him and expressing appreciation of the long service

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rendered, be drawn up and spread upon the records. This was duly seconded and passed.

The committee to draw up the resolution was appointed by the chair, viz.: H. L. Johnson, M. D., William T. Smith, M. D., and J. W. Parsons, M. D.

WHEREAS, We have to-day accepted the resignation of Dr. Granville P. Conn from the secretaryship of the New Hampshire Medical Society, which office he has filled faithfully and efficiently for nearly forty years;

Be it resolved, That we hereby express, on behalf of the New Hampshire Medical Society, our deep appreciation of the services Dr. Conn has so long and successfully rendered; and

Be it resolved, That this expression of our esteem and respect shall be incorporated in the records of the Society.

H. L. JOHNSON,
WILLIAM T. SMITH,
JOHN W. PARSONS,
Committee.

The resignation of D. E. Sullivan, M. D., as a member of the House of Delegates having been received, it was voted to accept the same.

The nominating committee reported as follows:

President—Ira J. Prouty, M. D.; A. P. Chesley, M. D.; H. D. W. Carvelle, M. D.

Vice-President—Arthur C. Heffenger, M. D.; John M. Gile, M. D.; John H. Neal, M. D.

Secretary—D. E. Sullivan, M. D.

Treasurer—D. M. Currier, M. D.

Councillors—For one year, Coös County, William H. Leith, M. D.; Carroll County, John H. Shedd, M. D.; for two years, Belknap County, A. H. Harriman, M. D.; Grafton County, M. S. Woodman, M. D.; for three years, Cheshire County, M. T. Stone, M. D.; Sullivan County, H. A. Hannaford, M. D.; for four years, Merrimack County, Charles R. Walker, M. D.; Hillsborough County, James T.

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Greeley, M. D.; for five years, Rockingham County, A. W. Mitchell, M. D.; Strafford County, Forrest L. Keay, M. D.

Delegate to the House of Delegates of the American Medical Association—John M. Gile, M. D.

Alternate to the House of Delegates of the American Medical Association—William T. Smith, M. D.

Delegate to the Dartmouth Medical College—W. J. Beattie, M. D.

It was voted that the report of the nominating committee be accepted.

It was voted to proceed to the election of officers, and the chair appointed H. L. Johnson, M. D., and E. E. Graves, M. D., as tellers, with the following result:

President—Ira J. Prouty, M. D.

Vice-President—John H. Neal, M. D.

Secretary—D. E. Sullivan, M. D., Concord.

Treasurer—D. M. Currier, M. D.

Councillors—For one year, Coös County, William H. Leith, M. D.; Carroll County, John H. Shedd, M. D.; for two years, Belknap County, A. H. Harriman, M. D.; Grafton County, M. S. Woodman, M. D.; for three years, Cheshire County, M. T. Stone, M. D.; Sullivan County, H. A. Hannaford, M. D.; for four years, Merrimack County, Charles R. Walker, M. D.; Hillsborough County, James T. Greeley, M. D.; for five years, Rockingham County, A. W. Mitchell, M. D.; Strafford County, Forrest L. Keay, M. D.

Delegate to the House of Delegates of the American Medical Association—John M. Gile, M. D.

Alternate to the House of Delegates of the American Medical Association—William T. Smith, M. D.

Delegate to the Dartmouth Medical College—W. J. Beattie, M. D.

Necrologist—E. E. Graves, M. D.

It was moved that the Secretary be impowered to cast one ballot for D. E. Sullivan, M. D., for five years, and he was declared elected.

It was then moved that the vote be reconsidered.

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It was voted that D. E. Sullivan, M. D., be elected to fill out the unexpired term for four years.

It was voted to ratify the action of the House of Delegates of last year in the election of D. M. Currier, M. D., as Treasurer for four years.

The Treasurer then read his report, and it was voted to accept the same.

TREASURER'S REPORT.

To the New Hampshire Medical Society:

Your Treasurer begs leave to make the following report for the year ending May 15, 1906:

DR.

1905.			
May 15.	To cash balance on hand as per last report . .	$538.43	
19.	cash from sale of dinner tickets . . .	106.00	
19.	cash received from exhibitors . . .	71.10	
1906.			
May 15.	To cash from fees and dues for the year . .	850.00	
	Amount	———	$1,565.53

CR.

1905.			
May 19.	By cash paid Eagle and Phenix Hotel Co. . .	$130.00	
19.	cash paid American Express Co. . . .	.50	
23.	cash paid S. M. Dinsmoor, M. D., trustees' bill	8.48	
27.	cash paid G. P. Conn, M. D., salary . .	100.00	
27.	cash paid G. P. Conn, M. D., bill of expense	42.95	

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May 27.	cash paid John F. Webster, use of hall . .	$25.00	
May 31.	cash paid D. M. Currier, M. D., salary . .	50.00	
31.	cash paid D. M. Currier, M. D., postage . .	10.07	
June 15.	cash paid Blaisdell's Orchestra . . .	15.00	
15.	cash paid Schubert Male Quartet . . .	21.00	
July 11.	cash paid S. S. Ford, janitor . . .	2.00	
Sept. 18.	cash paid Olin H. Chase, printing notices .	1.75	
Oct. 2.	cash paid Amy E. Lull, stenographer . .	15.00	
Nov. 14.	cash paid Ira C. Evans Co., printing . .	415.80	
Dec. 12.	cash paid American Express Co. . . .	47.64	
1906.			
Feb. 5.	cash paid Rumford Printing Co. . .	2.50	
Mar. 6.	cash paid American Express Co. . . .	2.10	
6.	cash paid Ira C. Evans Co.	2.50	
May 6.	cash paid Rumford Printing Co., registration book . . .	6.25	
	Amount		$898.54
Balance on hand			$666.99

Respectfully submitted,

D. M. CURRIER,

Treasurer.

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CONCORD, N. H., May 18, 1906.

We have this day examined the Treasurer's accounts and find them properly kept and correctly cast.

WILLIAM T. SMITH,
JOHN W. PARSONS,
Trustees N. H. Medical Society.

The report of the Board of Trustees was read, and it was voted to accept the same and place it on file.

TRUSTEES' REPORT.

CONCORD, N. H., May 18, 1906.

The Trustees of the New Hampshire Medical Society submit the following annual report:

The Bartlett fund, on deposit in the Portsmouth Savings Bank, bank book No. B 21,110, amounted at last report to	$2,580.88
July, 1905, interest	38.70
	$2,619.58
August 16, 1905, paid H. N. Kingsford, Secretary of the Dartmouth College building fund, the remaining 50 per cent. of the $1,000 given by the Society in 1904 for this purpose . .	500.00
	$2,119.58
January, 1906, interest	31.79
Total	$2,151.37

Three hundred and fifty-two dollars and eleven cents of this sum is by the terms of the bequest a permanent fund, leaving $1,799.26 to the order of the Society.

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The Pray fund, on deposit in the Strafford Savings Bank at Dover, bank book No. A 42, amounted at last report to	$1,143.41
January 1, 1906, interest	40.35
Total	$1,183.76

The original sum was $1,000, the increase only of which can be expended solely for prize essays.

The Society has also on deposit in the Portsmouth Trust and Guarantee Company, bank book No. 7,641, the sum of $591.93; in the Merrimack River Savings Bank, Manchester, bank book No. 26,934, the sum of $820.93; in the New Hampshire Savings Bank, Concord, bank book No. 35,696, the sum of $238.31; total amount in care of Trustees, $4,986.30, of which $3,634.19 can be expended by the Society.

The Trustees have received two essays for the Pray prize.

The prize has been awarded to the writer of the essay entitled "Home Treatment of Pulmonary Tuberculosis." The writer's name contained in the envelope accompanying the essay was found to be Henri T. Fontaine, of Pembroke.

A prize of one hundred dollars from the Pray fund is offered to the members of the Society for the coming year, concerning which circulars will soon be issued.

WILLIAM T. SMITH,
JOHN W. PARSONS,
Trustees.

An amendment was offered to Section 3, Chapter VI, of the by-laws as to the Treasurer and Trustees, and also a new section, No. 5, providing for a Board of Trustees and defining their duties:

SECT. 3. A bond shall be provided for the Treasurer at the expense of the Society whenever the House of Delegates shall deem it requisite. He shall demand and receive all

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dues assessed by the Society and other incidental revenue. He shall pay money out of the treasury only on bills approved by the Secretary. His accounts shall be audited by the Trustees and he shall annually make a report to the House of Delegates and to the Society.

SECT. 5. There shall be a Board of Trustees elected by the House of Delegates, one to serve one year, one to serve two years and one to serve three years, and after the first year one Trustee shall be elected at each annual meeting to serve three years. The Trustees shall be the custodians of all funds belonging to the Society. They shall audit the Treasurer's accounts and submit to the House of Delegates and to the Society a written report at the annual meeting. Whenever a vacancy occurs in the office of Treasurer, they shall assume the duties pertaining to the office until a Treasurer is elected by the House of Delegates. They shall constitute the Committee on Prize Essays, making such rules and regulations governing the same as may be necessary.

It was voted to adopt the amendment and additional section as presented.

The following names were presented for Trustees:

J. W. PARSONS, M. D., one year.
W. T. SMITH, M. D., two years.
S. M. DINSMOOR, M. D., three years.

They were declared elected for their respective terms.

It was voted that in 1907 the House of Delegates have their meeting on Wednesday evening at 7.30 o'clock and that the Secretary shall notify the members as to the place of meeting.

It was voted to accept the report covering the new names for membership in the Society.

The recommendation from the Council that all examinations for life insurance be made at a fee not less than $5, was laid upon the table.

The first report as to the resolution from the Council as to the word "contract physician" was accepted.

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The Council reported that any further action at the present time in the matter of "contract medicine" is inexpedient, and the matter of defining "contract medicine" was laid on the table.

The Council reported back that the matter of Edward J. Delaney had been considered and that he had been expelled from the New Hampshire Medical Society. It was voted to accept and adopt the report by the House of Delegates.

It was voted to continue the salaries of the Secretary and Treasurer as at present.

It was voted that the Secretary be instructed to notify Dr. Gleason that the matter of furnishing whiskey from a bottle in a physician's grip to a patient was not properly presented to the House of Delegates, and also that this matter be laid upon the table.

It was voted that the Secretary be authorized to send in on the proper date next spring the name of George Cook, M. D., for Medical Examiner.

It was voted to adjourn.

Adjourned.

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CONSTITUTION.

Article I.—Name of the Society.

The name and title of this organization shall be the New Hampshire Medical Society.

Article II.—Purposes of the Society.

The purpose of this Society shall be to federate and bring into one compact organization the entire medical profession of the state of New Hampshire, and to unite with similar associations in other states to form the American Medical Association, with the view to the extension of medical knowledge, and to the advancement of medical science; to the elevation of the standard of medical education, and to the enactment and enforcement of just medical laws; to the promotion of friendly intercourse among physicians, and to the guarding and fostering of their material interests; and to the enlightenment and direction of public opinion in regard to the great problems of state medicine; so that the profession shall become more capable and honorable within itself, and more useful to the public in the prevention and cure of disease, and in prolonging and adding comfort to life.

Article III.—Composition of the Society.

Section 1. This Society shall consist of Members, Honorary Members, Delegates and Guests.

Sect. 2. *Members.*—The members of this Society shall be the present members of the New Hampshire Medical Society and members of the county medical societies who shall hereafter join this Society.

Sect. 3. *Honorary Members.*—Medical men in this or other states who have acquired an honorable distinction in

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their profession, may be proposed by the House of Delegates as honorary members of this Society. A majority of two-thirds of all the votes cast shall be necessary to their election. In the printed list they shall be so distinguished.

SECT. 4. *Delegates.*—Delegates shall be those members who are elected in accordance with this Constitution and By-laws to represent their respective county societies in the House of Delegates of this Society.

SECT. 5. *Guests.*—Any distinguished physician, not a resident of this state, may become a guest during any annual session upon invitation of the Association or its Council, and shall be accorded the privilege of participating in all of the scientific work for that session.

ARTICLE IV.—HOUSE OF DELEGATES.

The House of Delegates shall be the legislative and business body of the Society, and shall consist of (1) delegates elected by the county societies, and (2) *ex officio*, the officers of the Society as defined in this Constitution.

ARTICLE V.—SECTIONS AND DISTRICT SOCIETIES.

The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of county societies.

ARTICLE VI.—SESSIONS AND MEETINGS.

SECTION 1. The Society shall hold an annual session, during which there shall be held daily not less than two general meetings, which shall be open to all registered members, delegates and guests.

SECT. 2. The time and place for holding such annual session shall be fixed by the House of Delegates.

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ARTICLE VII.—OFFICERS.

SECTION 1. The officers of this Association shall be a President, Vice-President, a Secretary, a Treasurer, and ten Councilors.

SECT. 2.—The President and Vice-President shall be elected for a term of one year. The Secretary, Treasurer and Councilors shall be elected for terms of five years each, the Councilors being divided into classes so that two shall be elected each year. All of these officers shall serve until their successors are elected and installed.

SECT. 3.—The officers of this Society shall be elected by the House of Delegates on the morning of the last day of the annual session, but no delegate shall be eligible to any office named in the preceding section, except that of Councilor, and no person shall be elected to any such office who is not in attendance upon that annual session and who has not been a member of the Society for the past two years.

ARTICLE VIII.—FUNDS AND EXPENSES.

Funds for meeting the expenses of the Society shall be arranged for by the House of Delegates by an equal per capita assessment upon each member, by voluntary contribution, and from the profits of its publications. Funds may be appropriated by the House of Delegates to defray the expenses of the annual sessions, for publication, and for such other purposes as will promote the welfare of the Society and profession.

ARTICLE IX.—REFERENDUM.

The general meeting of the Society may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates, and the House of Delegates may, by a similar vote of its own members, or after a like vote of the general meeting, submit any such question to the membership of the Society for a final vote; and if the persons voting shall comprise a majority of all the members, a major-

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ity of such vote shall determine the question, and be binding upon the House of Delegates.

Article X.—The Seal.

The Society shall have a common seal, with power to break, change or renew the same at pleasure.

Article XI.—Amendments.

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at that annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been sent officially to each county society at least two months before the session at which final action is to be taken.

BY-LAWS.

Chapter 1.—Membership.

Section 1. Members of the county societies shall be privileged to attend all meetings and take part in all of the proceedings of the annual sessions, and shall be eligible to any office within the gift of the Society.

Sect. 2. The name of a physician upon the properly certified roster of members or list of delegates of a chartered county society, who has paid his annual assessment, shall be *prima facie* evidence of his right to register at the annual session in the respective bodies of this Society, provided his name has been approved by the Council.

Sect. 3. No person who is under sentence of suspension or expulsion from any county society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Society, nor shall he be permitted to take any part in any of its proceedings until such time as he has been relieved of such disability.

Sect. 4. Each member in attendance at the annual session shall enter his name on the registration book, indicating

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the county society of which he is a member. When his right to membership has been verified by reference to the roster of his society, he shall receive a badge which shall be evidence of his right to all the privileges of membership at that session. No member or delegate shall take part in any of the proceedings of an annual session until he has complied with the provisions of this section.

Chapter II.—Annual and Special Sessions of the Society.

Section 1. The Society shall hold its annual session at such time and place as has been fixed at the preceding annual session (or as fixed by this Constitution and By-laws).

Sect. 2. Special sessions of either the Society or House of Delegates shall be called by the President at his discretion or upon petition of twenty delegates.

Chapter III.—General Meetings.

Section 1. The General Meetings shall include all registered members, honorary members, delegates and guests, who shall have equal rights to participate in the proceedings and discussions; and, except guests and honorary members, to vote on pending questions. Each general meeting shall be presided over by the President, or in his absence or disability, or by his request, by the Vice-President. Before it, at such time and place as may have been arranged, shall be delivered the annual address of the President, and the annual orations, and the entire time of the session, so far as may be, shall be devoted to papers and discussions relating to scientific medicine.

Sect. 2. The general meeting shall have authority to create committees or commissions for scientific investigations of special interest and importance to the profession and public, and to receive and dispose of reports of the same; but any expense in connection therewith must first be approved of by the House of Delegates.

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SECT. 3. Except by special vote, the order of exercises, papers and discussions as set forth in the official programme shall be followed from day to day until it has been completed.

SECT. 4. No address or paper before the Society, except those of the President and Orators, shall occupy more than twenty minutes in its delivery; and no member shall speak longer than five minutes, nor more than once on any subject.

SECT. 5. All papers read before the Society shall be its property. Each paper shall be deposited with the Secretary when read, and if this is not done it shall not be published.

CHAPTER IV.—HOUSE OF DELEGATES.

SECTION 1. The House of Delegates shall meet annually at the time and place of the annual session of the Society, and shall so fix its hours of meeting as not to conflict with the first general meeting of the Society, or with the meeting held for the address of the President and the annual orations, and so as to give delegates an opportunity to attend the other scientific proceedings and discussions so far as is consistent with their duties. But if the business interests of the Society and profession require, it may meet in advance, or remain in session after the final adjournment of the general meeting.

SECT. 2. Each county society shall be entitled to send to the House of Delegates each year two delegates, and for every one hundred members or major fraction thereof one additional delegate; but each county society in good standing with this Society, which has made its annual report as provided in this Constitution and By-laws, shall be entitled to two delegates.

SECT. 3. A majority of the registered delegates shall constitute a quorum, and all of the meetings of the House of Delegates shall be open to members of the Society.

SECT. 4. It shall, through its officers, advisory council, and otherwise, give diligent attention to and foster the scientific work and spirit of the Society, and shall constantly study and strive to make each annual session a stepping-stone to future ones of higher interest.

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SECT. 5. It shall consider and advise as to the material interests of the profession and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public-health legislation, and to diffuse popular information in relation thereto.

SECT. 6. It shall make careful inquiry into the condition of the profession of each county in the state, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality, and shall continue these efforts until every physician in every county of the state who can be made reputable has been brought under medical society influence.

SECT. 7. It shall encourage post-graduate work in medical centers, as well as home study and research, and shall endeavor to have the results of the same utilized and intelligently discussed in the county societies. (With these ends in view, five years after the adoption of these By-laws no voluntary paper shall be placed upon the annual programme or be heard in the Society which has not first been read in the county society of which the author is a member.)

SECT. 8. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-laws of that body in such a manner that not more than one half of the delegates shall be elected in any one year.

SECT. 9. It shall, upon application, provide and issue charters to county societies organized to conform to the spirit of this Constitution and By-laws.

SECT. 10. In sparsely settled sections it shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district and

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other classes of societies, and these societies, when organized and chartered, shall be entitled to all the privileges and representation provided herein for county societies, until such counties may be organized separately.

SECT. 11. It shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates, and such committees may report to the House of Delegates in person, and may participate in the debate thereon.

SECT. 12. It shall approve all memorials and resolutions issued in the name of the Society before the same shall become effective.

SECT. 13. It shall present a summary of its proceedings to the last general meeting of each annual session, and shall publish the same in the Transactions.

CHAPTER V.—ELECTION OF OFFICERS.

SECTION 1. All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect.

SECT. 2. The House of Delegates on the first day of the annual session shall select a Committee on Nominations consisting of ten delegates, no two of whom shall be from the same county society. It shall be the duty of this committee to consult with the members of the Society and to hold one or more meetings at which the best interests of the Society and of the profession of the state for the ensuing year shall be carefully considered. The committee shall report the result of its deliberations to the House of Delegates in the shape of a ticket containing the names of three members for the office of President and of Vice-President, and of one member for each of the other offices to be filled at that annual session. No two candidates for President and Vice-President shall be named from the same county.

SECT. 3. The report of the Nominating Committee and the election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the morning of the last day of the general session.

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SECT. 4. Nothing in this article shall be construed to prevent additional nominations being made by members of the House of Delegates.

CHAPTER VI.—DUTIES OF OFFICERS.

SECTION 1. The President shall preside at all meetings of the Society and of the House of Delegates; shall appoint all committees not otherwise provided for; shall deliver an annual address at such time as may be arranged; shall give a deciding vote in case of a tie, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and, as far as practicable, shall visit by appointment the various sections of the state and assist the Councilors in building up the county societies, and in making their work more practical and useful.

SECT. 2. The Vice-President shall assist the President in the discharge of his duties. In the event of his death, resignation or removal, the Vice-President shall succeed him.

SECT. 3. A bond shall be provided for the Treasurer at the expense of the Society whenever the House of Delegates shall deem it requisite. He shall demand and receive all dues assessed by the Society and other incidental revenue. He shall pay money out of the treasury only on bills approved by the Secretary. His accounts shall be audited by the Trustees and he shall annually make a report to the House of Delegates and to the Society.

SECT. 4. The Secretary acting with the Committee on Scientific Work, shall prepare and issue the programmes for and attend all meetings of the Society and of the House of Delegates, and he shall keep minutes of their respective proceedings in separate record books. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the Treasurer, and shall keep account of and promptly turn over to the Treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates at the annual sessions. He shall keep a card-index register of all the legal

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practitioners of the state by counties, noting on each his status in relation to his county society, and upon request shall transmit a copy of this list to the American Medical Association for publication. In so far as it is in his power he shall use the printed matter, correspondence, and influence of his office to aid the Councilors in the organization and improvement of the county societies, and in the extension of the power and usefulness of this Society. He shall conduct the official correspondence, notifying members of meetings, officers of their election, and committees of their appointment and duties. He shall act as chairman of the Committee on Scientific Work and on Publication. He shall employ such assistants as may be ordered by the Council or the House of Delegates. He shall annually make a report of his doings to the House of Delegates.

In order that the Secretary may be enabled to give that amount of time to his duties which will permit of his becoming proficient, it is desirable that he should receive some compensation. The amount of his salary shall be fixed by the House of Delegates.

SECT. 5. There shall be a Board of Trustees elected by the House of Delegates, one to serve one year, one to serve two years and one to serve three years, and after the first year one Trustee shall be elected at each annual meeting to serve three years. The Trustees shall be the custodians of all funds belonging to the Society. They shall audit the Treasurer's accounts and submit to the House of Delegates and to the Society a written report at the annual meeting. Whenever a vacancy occurs in the office of Treasurer, they shall assume the duties pertaining to the office until a Treasurer is elected by the House of Delegates. They shall constitute the Committee on Prize Essays, making such rules and regulations governing the same as may be necessary.

CHAPTER VII.—COUNCIL.

SECTION 1. The Council shall hold daily meetings during the annual session of the Society and at such other times as

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necessity may require, subject to the call of the Chairman or on petition of three Councilors. It shall meet on the last day of the annual session of the Society for reorganization and for the outlining of work for the ensuing year. At this meeting it shall elect a Chairman and Secretary, and it shall keep a permanent record of its proceedings. It shall, through its Chairman, make an annual report to the House of Delegates at such time as may be provided.

SECT. 2. Each Councilor shall be an organizer, peacemaker, and censor for his district. He shall visit each county in his district at least once a year, for the purpose of organizing societies where none exist, for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his doings, and of the condition of the profession of each county in his district to each annual session of the House of Delegates. The necessary traveling expenses incurred by such Councilor in the line of the duties herein imposed may be allowed by the House of Delegates upon a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Society.

SECT. 3. Collectively the Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the county societies or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or of a county society, upon which an appeal is taken from the decision of an individual Councilor. Its decision in all such cases shall be final.

SECT. 4. The Council shall have the right to communicate the views of the profession and of the Society in regard to health, sanitation, and other important matters to the public and the lay press. Such communications shall be

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officially signed by the Chairman and Secretary of the Council, as such.

Chapter VIII.—Committees.

Section 1. The standing committees shall be as follows:

A Committee on Scientific Work.

A Committee on Public Policy and Legislation.

A Committee on Publication.

A Committee on Nominations.

A Committee on Arrangement, and such other committees as may be necessary. Such committees shall be elected by the House of Delegates unless otherwise provided.

Sect. 2. The Committee on Scientific Work shall consist of three members, of which the Secretary shall be a member and chairman, and shall determine the character and scope of the scientific proceedings of the Society for each session, subject to the instructions of the House of Delegates or of the Society, or to the provisions of the Constitution and By-laws. Thirty days previous to each annual session it shall prepare and issue a programme announcing the order in which papers, discussions and other business shall be presented, which shall be adhered to by the Society as nearly as practicable.

Sect. 3. The Committee on Public Policy and Legislation shall consist of three members and the President and Secretary. Under the direction of the House of Delegates it shall represent the Society in securing and enforcing legislation in the interest of the public health and of scientific medicine. It shall keep in touch with professional and public opinion, shall endeavor to shape legislation so as to secure the best results for the whole people, and shall utilize every organized effort of the profession to promote the general influence in local, state and national affairs and elections. Its work shall be done with the dignity becoming a great profession and with that wisdom which will make effective its power and influence. It shall have authority to be heard before the entire Society upon questions of great concern at such time as may be arranged during the annual session.

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SECT. 4. The Committee on Publication shall consist of three members, of which the Secretary shall be one and chairman, and shall have referred to it all reports on scientific subjects, and all scientific papers and discussions heard before the Society. It shall be empowered to curtail or abstract papers and discussions, and any paper referred to it which may not be suitable for publication in the Transactions may be returned to the author. The committee shall have authority to arrange for the publication and distribution of the Transactions after receiving competitive bids, and shall use diligence in getting them into the hands of the members. All papers read before the Society shall be the property of the Society.

SECT. 6. The Committee on Nominations shall be appointed and perform its duties in accordance with the provisions of Chap. V, Sect. 2, of these By-laws.

SECT. 7. The Committee of Arrangements shall consist of the county society in the territory in which the annual session is to be held. It shall, by committees of its own selection, provide suitable accommodations for the meeting-places of the Society and of the House of Delegates, and of their respective committees, and shall have general charge of all the arrangements. Its chairman shall report an outline of the arrangements to the Secretary for publication in the programme, and shall make additional announcements during the session as occasion may require.

CHAPTER IX.—ASSESSMENTS AND EXPENDITURES.

SECTION 1. An assessment of two dollars per capita on the members is hereby made the annual dues of this Society. The Secretary of each county society shall forward its roster of all officers and members, list of delegates, and list of non-affiliated physicians of the county to the Secretary of this Society thirty days in advance of each annual session (or on or before some specified date).

SECT. 2. Any county society which fails to make the reports required, on or before the date above stated, shall be held as suspended, and none of its members or delegates shall

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be permitted to participate in any of the business or proceedings of the Society or of the House of Delegates until such requirements have been met.

SECT. 3. All motions or resolutions appropriating money shall specify a definite amount, or so much thereof as may be necessary for the purpose indicated, and must be approved by the Council and House of Delegates on a call of the ayes and noes.

CHAPTER X.—RULES OF CONDUCT.

The principles set forth in the Code of Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

CHAPTER XI.—RULES OF ORDER.

The deliberations of this Society shall be governed by parliamentary usage as contained in Roberts' Rules of Order, unless otherwise determined by a vote of its respective bodies.

CHAPTER XII.—COUNTY SOCIETIES.

SECTION 1. All county societies now in affiliation with the State Society or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and By-laws, shall, upon application to the House of Delegates, receive a charter from and become a part of this Society.

SECT. 2. As rapidly as can be done after the adoption of this Constitution and By-laws, a medical society shall be organized in every county in the state in which no society exists, and charters shall be issued thereto.

SECT. 3. Charters shall be issued only upon approval of the House of Delegates and shall be signed by the President and Secretary of this Society. The House of Delegates shall have authority to revoke the charter of any county society whose actions are in conflict with the letter or spirit of this Constitution and By-laws.

SECT. 4. Only one medical society shall be chartered in any county. Where more than one county society exists,

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friendly overtures and concessions shall be made, with the aid of the Councilor for the district if necessary, and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Council, which shall decide what action shall be taken.

SECT. 5. Each county society shall judge of the qualification of its own members, but, as such societies are the only portals to this Society and to the American Medical Association, every reputable and legally registered physician who is practising, or who will agree to practise, non-sectarian medicine shall be entitled to membership. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every such physician in the county to become a member.

SECT. 6. Any physician who may feel aggrieved by the action of the society of his county in refusing him membership, or in suspending or expelling him, shall have the right of appeal to the Council and to the House of Delegates.

SECT. 7. In hearing appeals the Council may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a board and as individual councilors in district and county work, efforts at conciliation and compromise shall precede all such hearing.

SECT. 8. When a member in good standing in a society moves to another county in this state, his name, upon request, shall be transferred without cost to the roster of the county society into whose jurisdiction he moves.

SECT. 9. A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he resides.

SECT. 10. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral, and material condition of every physician in the county; and systematic efforts shall be made by each member,

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and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

SECT. 11. Frequent meetings shall be encouraged, and the most attractive programmes arranged that are possible. The younger members shall be especially encouraged to do post-graduate and original research work, and to give the Society the first benefit of such labors. Official position and other preferments shall be unstintingly given to such members.

SECT. 12. At some meeting in advance of the annual session of this Society, each county society shall elect a delegate or delegates to represent it in the House of Delegates of this Society, in the proportion of two delegates and one additional to each one hundred members or major fraction thereof, and the secretary of the society shall send a list of such delegates to the Secretary of this Society, at least ten days before the annual sessions.

SECT. 13. The secretary of each county society shall keep a roster of its members, and a list of the non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practise in this state, and such other information as may be deemed necessary. He shall furnish an official report containing such information, upon blanks supplied him for the purpose, to the Secretary of this Society, thirty days in advance of each annual session, and at the same time that the dues accruing from the annual assessment are sent in. In keeping such roster the secretary shall note any changes in the personnel of the profession by death, or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

CHAPTER XIII.—AMENDMENTS.

These By-laws may be amended at any annual session by a majority vote of all the delegates present at that session, after the amendment has laid upon the table for one day.

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PRESIDENT'S ADDRESS.

BY F. A. STILLINGS, M. D., CONCORD.

Members of the New Hampshire Society:

In casting about for some subject on which to address you briefly, I found that past Presidents had allowed themselves a wide range of subjects. Ethics, morals, science, and the religious duties of the doctor have all been treated, but I have failed to find any reference to the profession of medicine from a business standpoint.

I am well aware that in touching upon the points I have in mind, that I shall perhaps lay myself open to the charge of viewing the practice of medicine from a mercenary standpoint, but I hasten to disavow any such intent.

The remuneration of doctors from the earliest history has been a very uncertain factor in their lives and progress.

Starting originally, so far as we can learn, from a religious body of men, the medical profession has, up to the present day, been unable to separate itself entirely from the original idea of doing good without reward, or at least only such reward as was given as an honorarium.

It has been truly said: "The history of medicine is closely interlinked with the development of theology." "The errors of one are for the most part reflected in the mistakes of the other. Faith and superstition are both children of the same family, and medico-physical knowledge originally found expression exclusively through religious teaching."

Among the Egyptians, "the cat-headed goddess Bubastis was believed to deal out to mothers the blessings of fertility. Ibis showed an especial interest in those human beings who

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were troubled with disturbances of digestion and this interest found benevolent expression in the invention of the clyster."

With the Greeks also, the gods rendered services to diseased humanity. Thus Apollo invented the art of healing, and if time permitted he occasionally lent a hand when difficulties beset the entrance into this world of a young mortal.

Usually, however, Aphrodite attended to such cases, as she was supposed to know more about the results of love affairs.

The goddess Athene was a successful ophthalmologist and got a temple dedicated to her by Lycurgus, because she cured him of sore eyes.

The priests, who acted as physicians, were on excellent terms with these gods and goddesses who could only be induced to act for the good of the patient, by the request of the priests, and before they could see their way clear to importune the gods it was necessary for the suppliant to give an honorarium.

I have seen in a large vaulted room in a church edifice, a circular stone basin, standing about four feet high and about six feet in diameter. In the bottom of this basin was carved the head of a god with open mouth. Thirty or forty feet away hung a large curtain. I was told to bend over and whisper any question I wished answered.

I did so and said, "How do you feel to-day?" and immediately the reply came, apparently from the stone god's open mouth, "Pretty well, thank you."

I was then shown on the other side of the curtain, at the extreme end of the hall, another basin like the first.

The priests had arranged these basins and so constructed the ceiling of the room that sound carried from one basin to the other.

When a patient came to be treated he leaned over the edge of the first basin, and told the stone god his troubles and asked for help.

The priest who was listening at the other basin told him first how much money he must deposit in order to receive help, then that his case would be taken under consideration,

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and finally probably added that he would be all right "if there did n't anything new set in."

This is such a common saying that it must have come from the early days.

The priest-doctor of those days evidently had an eye to the business end of his profession, as well as the religious, and I have been much interested to find how skillful the learned priests in the early ages were in separating the members of their flock from their money or other worldly possessions.

It would seem that as general intelligence increased throughout the world, there arose here and there a class of men, who, though not belonging to the priesthood, yet felt impelled to heal the sick; and as they were not on intimate terms with the gods and goddesses, they became Magi, and began the cure of disease by magic.

These gentlemen also became very expert in gathering in the coin of the realm, in many instances beating the priests at their own game.

For a long time it was believed that certain gods punished man by making him fall ill, and both priests and Magi demanded pay, the one for beseeching, and the other for outwitting, the powers.

Centuries following this came the one God, who caused all disease, pestilence, and famine as a punishment to those who had aroused his wrath, and the priests spent all their time in appeals to him, and for a time they had the Magi on the hip.

The magicians, however, soon seized upon a former theory of the priests, that the devil was responsible for much of the trouble in the world, and devoted themselves to relieving humanity of its woes and ills, by practising their arts against the evil spirits, and again did a rushing business.

It is interesting to note that the so-called magicians of the present day advertise themselves by having the cloven-footed gentleman represented on the advertising billboard alongside their own picture, only at the present time they are not opposed, but are in league with him.

By this time, however, another class of men had partially

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separated themselves from the priesthood, and were known as physicians, and these held a physico-mechanical theory of life in the realm of medicine; but they were a feeble folk, and not in much repute, as note in the Bible a report of the case of Asa, which for sarcasm is unequalled.

It says:

"And Asa was sore afflicted, and he sought not council of the Lord, but rather of the physicians, and Asa slept with his fathers." From this statement it would seem not improbable that there were Christian Scientists in those days.

It also appears that there grew to be a very close relation between the priests and magicians, and the latter were later blessed by the priests, and the individual thus honored bore the proud title, "conqueror of evil," and was then a member of the medical fraternity in good standing.

The ancient Greek priests gave great medical significance to dreams and had temples where the sick could go for a "temple sleep," the same as we moderns go for a Turkish bath; but before the sick man could have a bed in the temple, he was obliged to give a fixed sum, and his dream "was the medical advice of the Divinity in its most direct form." The patient then had to repeat his dream to the priest, who interpreted it for him, and extracted the "medical efficacy."

Occasionally, however, the patient would fail to dream, and to the credit of the priest, be it said, that he himself would drop off to sleep and have a dream which he would interpret for the benefit of his patient.

But the feeble folk, that is to say the physicians, who believed in the physico-mechanical theories of life, plodded along as best they could, relieving the sick as best they knew how, although I can nowhere find any mention of their acquiring great wealth.

After a time, however, their followers increased, and as a body they became strong enough to cause the priests and magicians first to fight them, and later to copy many of their methods of practice, especially the magicians, who went further and actually used everything under the sun as a remedy.

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It would seem that these magicians inoculated some of the physicians with their ideas, concerning the usefulness of many medicines which have been handed down from generation to generation, and still have a strong hold to-day.

Through many ages these feeble folk, seekers after the best methods of healing the sick, often deluded into turning into by-paths of error in pursuit of knowledge which would help them in their fight against disease and death, have gone steadily on, often profiting by their mistakes, and putting the rest of their brethren on their guard against similar errors, but as a class they have never been accused of having any business ability.

The medical profession has in name broken away from the priesthood, but still bears the mantle of charity with which the church once invested it, and this mantle in which we are enveloped, but through which we can see readily if we will but look, blinds the majority of present day physicians to their business duties.

In this present century it is to be hoped that the physician will develop more business acumen, more self-reliance and more self-respect.

I do not mean that he shall do less charitable work, but that he shall be his own judge of the kind of charitable work he shall do.

No man before me but has been approached by some person of more means than himself, with a request to do charity work, only to find after the work has been done, that the recipient had thanks only for the charitable person who had the business acumen to get some one else to carry out his scheme.

Every physician should choose his own charity cases, and keep a strict account of what he does in this direction. He should, however, be careful not to credit the bills he finds himself unable to collect to this account, thereby making it appear that he has been extremely charitable. Uncollectable bills should be charged to profit and loss, where they belong.

Public hospitals intended for the poor should, and always do, secure the cordial support of the physician, but when people of means make use of the hospital by paying large sums

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for private rooms, it is a poor business policy for the physician to treat them for nothing, and he should invariably refuse

So-called charitable homes or institutions, although they may be rolling in wealth, acquired by gifts from charitable people, or those who are desirous of leaving a monument to themselves, are always run by a board of managers, who, after arranging to pay for the services of all the other employes, look about for some member of the medical profession to go and spend his time and strength in caring for its inmates without remuneration of any sort; and so lacking is the profession in business ability and self-reliance, that the chosen one gratefully accepts the chance to work for nothing.

If an institution of this sort be poor, no physician should hesitate to contribute his services; but if it be endowed, he should be paid his regular fee.

Another instance where the physicians of the present day show little business ability, is where they allow themselves to be induced to do county, city and town work for little or nothing.

County commissioners, overseers of the poor, and selectmen have never been known to perform their duties without a proper recompense, but they have the business acumen to offer to physicians about twenty-five cents on the dollar for their work, and they have always found some physician with so little self-reliance and business ability that he accepts it.

In my opinion, no physician ever did county, city or town work at reduced rates, that it did not injure him in a business way in his community, whether he is made aware of it or not.

Just at present the subject of contract work is agitating the professional mind in a large degree, and the public mind in a much less degree. Acceptance of contract work is the result of poor business ability on the part of the professional man.

Any man who does contract work shows that he feels he has not sufficient ability to secure his livelihood in open competition with the other members of the profession in his immediate vicinity, and also shows that he has not the high business principles which should actuate every man in or out of the profession.

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I imagine that every man who enters into contract work does so with the hope that he will get a part of something for nothing. This is nothing more or less than the spirit of graft, which is so rampant to-day, and the spirit of graft has no place in the proper scheme of professional life.

There is no good reason why professional work should be done for town, city, or county for a smaller fee than would be charged to the selectmen, mayor, or county commissioners, nor is there any good reason why the former should be charged more than the latter.

Professional work for either party should be charged for exactly according to the usual fees in the locality in which the physician resides.

Nobody ever heard of a lawyer defending a suit against town, city, or county at a rate of twenty or twenty-five cents on a dollar. The lawyer who would take such cases on those terms is not the one town, city, or county would employ if a suit were brought against them.

I am told that a city physician, who contracted to do the city work for a certain sum, found at the end of the year that so few visits had been made, that he had received eight dollars a visit in a city where the regular fee was a dollar and a half.

I am happy to say that this physician declines to do contract work any longer, and if the city in which he lives continues to employ him, they will pay him a dollar and a half a visit, instead of eight dollars as they have for a year under the contract. Meanwhile the doctor will have gained in self-respect, and I believe he will gain in legitimate business much more than he has lost.

I also believe that any city or town that continues to employ a physician, who takes the manly business stand this physician has taken, will receive better service and at less expense than under contract work.

Occasionally there appears among the profession a man who will deliberately resort to any unfair means to secure business for himself at the expense of his competitors. When such a one develops in a community, I know of no better business way of dealing with him than to utterly ignore him.

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Telling the public of his unfair methods does no good, as he will simply pose as a martyr and claim that the telling is caused by professional jealousy, and with professional jealousy the public has no sympathy, but is inclined to side with its object.

A former practice, common among physicians, but which I hope is very uncommon now, was "cutting under" and showed how lacking a portion of the profession were in business acumen.

I can conceive of but two reasons by which a physician could convince himself of the desirability of such a practice; one is to do it in an effort to injure his competitor by getting his business away from him, and the other is to earn a certain amount in order to support himself. The latter is the better, and probably the most common reason, but both are poor.

It has been found in the business world that cutting prices kills the business, while competition increases its value; and the same rule holds good in professional work.

If instead of trying to get your competitor's business by cutting under him, you hold to the regular fee in your vicinity, and try to get more work than he, because you have made yourself a better physician, there will soon be two excellent doctors in that community whose sphere of action will have become so wide that there is room for a third; while the "cutting under" process will result in one, and probably two doctors poor in purse and ability.

Much could be said along this line, but I shall not take your time beyond suggesting the following rules:

1st. Give your services freely to the needy, but be your own judge as to whom the needy one is.

2d. Among the paying patients charge the regular fee and collect it.

3d. Do not charge the patient with large means four or five times as much as your ordinary fee bill allows, as this is graft, pure and simple; and if you excuse yourself by saying that you do so because of charity work, you destroy your own record of charitable work, by making some one else pay the bills.

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DIPHTHERIA.

BY C. F. OBER, M. D., MANCHESTER.

Mr. President:

In presenting a paper on the subject of diphtheria, I think we will all agree that it would be time thrown away to say anything about the *history* of diphtheria, or to discuss the theories which were commonly accepted by the profession a long time ago. It will serve our purpose much better if we simply speak of the theories which prevail at the present time.

In a paper of this kind it would also seem to be folly to attempt to cover the whole subject of diphtheria in the time allotted, and I therefore have thought it best to simply consider the *ætiology*, the *diagnosis*, the *complications* and the *treatment*.

I would like, however, to first look back about twelve years, for the purpose of calling attention to the theory presented by Professor Cameron, of McGill University. In his article on diphtheria in Hare's Therapeutics, he said that the mind of the profession had been confused by the fierce fight between the localists and constitutionalists.

His belief is, or at least *was* at that time, that diphtheria is a local specific disease, due to the presence and action of bacilli; characterized by a deposit of pseudo-membrane at the site of infection; accompanied by constitutional disturbance and followed by nervous symptoms due to the absorption into the circulation of toxalbumin.

He also believes that diphtheria and membranous croup are identical and says that those physicians who believe that true croup is diphtheria and contagious, and who base their

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treatment on this belief, will succeed in saving the most lives and limiting the spread of the disease.

He argues that in order to treat diphtheria understandingly and successfully one must be able to answer the question, "Is diphtheria *at first* a local or a constitutional disease."

Welch says diphtheritic bacilli develop only locally at the site of infection and are found only in the pseudo-membrane, mostly on the surface, not even in the subjacent mucous membrane; they do not invade the tissues or circulation, but they generate, at the point of entrance, a highly poisonous chemical substance, the absorption of which produces the constitutional symptoms.

Let us remember that the above was written about twelve years ago, before the advent of *antitoxin*, which was first used in 1895.

In the light of our *present* knowledge, it would seem to be wiser to consider diphtheria *constitutional* from the *first* with a *local* manifestation and to commence *at once* both local and constitutional treatment.

At the end of my paper I shall say considerable about this, but wish to speak now of the

ÆTIOLOGY.

In Parkes' "Handbook of Infectious Diseases," I have found a very concise summary of eight sources of diphtheritic infection, viz.:

1. From a previous case either acute or convalescent.
2. From a case of apparently simple tonsilitis.
3. From a case of apparently simple nasal ulceration or ozæna.
4. From domestic animals, as cats, pigeons or fowls.
5. From cow's milk, by human infection of the milk in cow sheds and dairies.
6. From infected bedding, clothes, carpets, curtains, books, toys, cups, spoons, forks, etc.
7. From a person who has been in contact with a diph-

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theritic patient, but who has not himself contracted the disease.

8. From defective sanitary conditions.

Right here I would like to add the opinion that a *ninth* source of infection may sometimes be found in the common practice in many towns and cities of furnishing a common stock of pencils, penholders, etc., for the use of school children.

These articles are gathered up every school session and distributed again the next session, and it is a well known fact that both boys and girls will often hold such articles in their mouths more or less of the time. However, in many schools various devices have been put into use for the purpose of securing the same pencils to the same scholars at each school session.

It is believed that there are scattered among the general public a considerable number of persons, even if they have not been recently and directly exposed to diphtheria, who have typical diphtheritic bacilli in their throats, and it would seem that the occupation of the individual makes him more or less dangerous as the case may be.

For instance, those who are engaged in handling articles of food, as milk men and those whose work brings them in close contact with small children—as nurses—are more likely to spread the disease than persons working at trades or in stores.

DIAGNOSIS.

It is evident that early and exact diagnosis is very necessary. As physicians are most likely to make mistakes in distinguishing between diphtheria and follicular tonsilitis, I will insert here a little table which I have found very useful in making a differential diagnosis between the two diseases.

1. In diphtheria *glandular swelling* is almost invariably *present*. In follicular tonsilitis it is usually *absent*.

2. Diphtheria often does not reach its height for four or

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five days. Follicular tonsilitis often does in twenty-four to thirty-six *hours*.

3. *Nasal* symptoms. In diphtheria regurgitation and bloody discharge are often present; in follicular tonsilitis neither one.

4. In regard to the *membrane*. In diphtheria it *may not* be visible for two days; in follicular tonsilitis it is usually present at the first visit. In diphtheria the membrane is frequently *uni*-lateral for a day or two; in follicular tonsilitis almost always *bi*-lateral *at once*. In diphtheria the membrane clears off *slowly*, sometimes lasting five to ten days, though it clears more quickly if *antitoxin* is used; in follicular tonsilitis it clears off *quickly*, often in two to four days.

A prompt detection cannot be made in all cases by a clinical diagnosis—no matter how skillful the diagnostician.

To be absolutely certain the *culture test* must be applied.

Hare says the only pathognomonic feature of diphtheria invariably present is the specific micro-organism known as the *Klebs-Löffler* bacillus, and the only way that a positive diagnosis can be reached is to have a bacteriological examination made.

Whenever such an examination reveals the Klebs-Löffler bacilli the physician knows positively that he has in hand a case of diphtheria.

The Bulletin of the Delaware Bacteriological and Pathological Laboratory, issued about two and one half years ago, says, "If the physician sends to the laboratory a cotton swab which has been rubbed over the membrane, or inflammed portion of the throat, the laboratory *may* or *may not* prove the presence of true diphtheria. If the result is *positive*, the case is one of diphtheria and is at once to be treated with antitoxin and isolated to prevent infection of others, but if it is *negative* the antitoxin treatment is useless."

Right here I would like to record my belief that it is better to give at least one proper dose of antitoxin *at once* in any suspected case without waiting till we hear from the laboratory.

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Sometimes it has been found that certain forms of mild sore throat, which hardly any physician would think of calling diphtheria, have revealed the presence of true diphtheritic germs.

The true nature of such cases needs to be recognized and the laboratory alone can settle such questions.

In June, 1893, the State Board of Health instructed the local boards and physicians of New Hampshire to regard all membranous deposits as diphtheria and to take the same precautions as for diphtheria. Many physicians have come to the conclusion that membranous croup is only a form of diphtheria, and Dr. John B. Roberts, of Philadelphia, says it makes no difference to him whether some pathologists call it croup and some diphtheria, *he* calls them all diphtheria, and he advises physicians to always report these cases as diphtheria.

Dr. Herman Biggs, of New York, reported to the New York City Board of Health the results of bacteriological examinations of thirty-six cases of so-called membranous croup. In thirty out of the thirty-six cases, the Klebs-Löffler bacillus of diphtheria was abundantly present.

During the space of four months nearly eighty-four per cent. of cases of so-called membranous croup reported to the health department proved to be genuine diphtheria.

In January, 1900, Dr. Denny, of Brookline, Mass., read a paper at a meeting of the Norfolk District Medical Society, which was based upon practical experience as a bacteriologist.

This paper illustrates one way in which diphtheria may be accounted for without direct exposure to a prior case—through infection carried in the throats of well persons.

The occurrence of the Klebs-Löffler bacillus in the throats of healthy persons who have never shown any symptoms of diphtheria, has caused much misunderstanding among physicians.

Nurses who have been taking care of diphtheria patients frequently have the bacillus in their throats, though they do not develop diphtheria themselves.

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Another puzzling condition of things is illustrated in a paper by Dr. W. G. Bissell, bacteriologist, of Buffalo, N. Y., in which he shows that certain conditions of the throat, clinically looking like diphtheria, may be produced by other germs, and may need a different treatment, as, for instance, by antistreptococcus serum. This again shows the importance of an early bacteriological examination.

Osler says, "The presence of the Klebs-Löffler bacillus is regarded by bacteriologists as the sole criterion of true diphtheria, and as this organism may be associated with all grades of throat affection, from a simple *catarrh* to a sloughing, *gangrenous* process, it is evident that in many instances there will be a striking discrepancy between the *clinical* and the *bacteriological* diagnosis.

"One inestimable value of recent studies has been the determination of the diphtheritic character of many milder forms of tonsilitis and of pharyngitis." He also says, "Where a bacteriological examination cannot be made the physician must regard as *suspicious* all forms of throat affection in children, for mistakes are most likely to occur in the various lighter forms of membranous angina, many of which are in reality due to the Klebs-Löffler bacillus." Other infections may simulate diphtheria and it has been shown that many mild cases and some fatal ones, having clinically the appearance and symptoms of diphtheria, do not reveal the existence of the bacillus of diphtheria, but are due to some other form of infection.

Sternberg says, "In certain forms of diphtheria, and especially when it occurs as a complication of scarlet fever, measles and other diseases, the Klebs-Löffler bacillus is *absent* and a streptococcus is found in considerable numbers which is probably the cause of the diphtheritic inflammation."

In the *Sanitary Bulletin* for January, 1902, the editor cautions physicians against making the mistake of relying upon a *single* bacteriological examination, when that proves *negative*. He says that a *single negative* result should not,

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in the least, swerve the attending physician from his candid judgment of the case from a *clinical* standpoint.

In a mild case of diphtheria or in the earlier stages of the disease, in any case there may be but few bacilli, and they may be hidden in the folds or follicles of the mucous membrane, so that in using the swab it fails to take up any of the germs, and of course a negative culture in the laboratory will be the result.

In *all* cases where the clinical symptoms continue, following a first negative result, subsequent specimens should be taken *daily* until at least *three* negative results have been obtained, unless a *positive* result should be determined before. Able authorities have concluded that bacteriological examinations for *release* from *quarantine* would insure better public protection against diphtheria.

They would also shorten the average period of *isolation* and lessen the expenses in a large number of cases.

COMPLICATIONS.

The sequelæ most frequently observed are of nervous origin in the different forms of paralysis.

The most common form of paralysis is that of the soft palate, when the voice becomes *harsh* and *nasal*, and fluid regurgitates through the nostrils.

Next in frequency comes certain eye troubles, as paralysis of the ciliary and ocular muscles. When the ciliary muscles are involved we may find loss of accommodation and when the oculo-motor muscles are affected there may be strabismus. Next in frequency is paralysis of the muscles of the lower extremities, usually preceded by a feeling of coldness, numbness, tingling or pain, though there *may* be anæsthesia. The upper extremities may be similarly attacked or one set of muscles may alone be affected.

TREATMENT.

Physicians of the present day are obliged to answer one question when they are called to a case of diphtheria, that in

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former times they were not required to answer, viz.: "Shall I use antitoxin?"

In regard to the use of it, I think all physicians may be divided into three classes: 1. Those who depend on antitoxin alone. 2. Those who use it in connection with *other* treatment. 3. Those who *will not* use it at all.

Antitoxin was first used in 1895, and after it had been in use some over four years, the American Pediatric Society reported upon its use in five thousand seven hundred and ninety-four cases, which occurred in the practice of six hundred and fifteen different physicians, who pronounced strongly in its favor, as the results showed a diminution in the mortality from 12.3 per cent. to 7.3 per cent.

A writer in the *Medical News*, advocating *promptness* in the use of antitoxin, says that *all* cases *recovered* in which antitoxin was used on the *first day;* 2 per cent. died when it was used on the second day; 10 per cent. died when it was used on the third day; 20 per cent. died when treatment was begun on the fourth day; and 33 per cent. died if antitoxin was not given first till the fifth day. This shows the great importance of using it on the first day.

It seems to me that a young physician just starting in practice must find himself somewhat bewildered when he meets his first case of diphtheria, to decide what line of treatment he had better employ.

I judge he would be bewildered because in a recent work on therapeutics I find a list of about fifty remedies mentioned as being used in the treatment of diphtheria, and it seems to leave the young physician to *take his choice* between them, without much help or guidance.

If I were called upon to give advice to a young physician who had a case of diphtheria on his hands, I would advise him, *first of all*, to inject a proper-sized dose of *antitoxin*, and *then* send a culture tube to the nearest bacteriological laboratory.

As soon as that was done I would advise him to commence at once to saturate the patient's system with the *sulphide of*

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calcium, which at the present time is being used very successfully in many parts of the United States in the treatment of diphtheria.

In the third place I would advise him to very frequently spray the throat and nose with the *peroxide of hydrogen*—using a *good* throat atomizer.

If he carried out these three measures *persistently* and *thoroughly*, doing *no half-way* work, I should expect the young man to save a very large majority of his diphtheria patients.

As the sulphide of calcium is attracting considerable attention, it may be well to state just how it acts. In the first place it is called our *best systemic antiseptic*, and it is decomposed in the gastro-intestinal canal into the sulphate of lime and sulphuretted hydrogen. The sulphate of lime passes out of the system with the feces, and the sulphuretted hydrogen is absorbed by the blood and eliminated through the glands of the skin and of the mucous membrane of the respiratory tract. The breath of the patient who is taking this remedy is heavily charged with the odor of sulphuretted hydrogen—that is, if the physician is using a *reliable* preparation—and sometimes the perspiration is also. While this gas passes through the mucous membrane, it stimulates the function of the mucous glands. If these glands have not been destroyed by ulceration, the secretion of mucus may still continue under the false membrane, which then becomes soft and loose and is sometimes detached in flakes. While the germicidal property of sulphuretted hydrogen is not very great, its beneficial effects are produced through its action upon the mucous glands.

If a physician does not obtain *good results* from the use of calcium sulphide, I think it may be because he has not succeeded in purchasing a *reliable* article, as I have tried the products of several firms and found them to be *wholly inert*. The ordinary tablet triturate will *soon* spoil from oxidation and physicians should *remember this* or they will be probably disappointed.

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Sometimes in diphtheria the patient will need moderate doses of strychnia to fortify the heart and sustain the nervous system.

In the *laryngeal* form of diphtheria, in addition to the above treatment I should make use of *steam*.

With *adult* patients the steam atomizer may be used, but with children it is often better to construct a sort of tent over the bed, so that the child may breathe a steam-saturated air. The steam may be used plain or medicated, as preferred; but I believe it is often wise to use something like the oil of turpentine, to which a little oil of eucalyptus may be added.

When these measures are *thoroughly carried out* I believe it will hardly ever be necessary to resort to either intubation or tracheotomy.

CONCLUSION.

What the generally accepted treatment of diphtheria will be in five or ten years from now, none of us can say; but, judging from numerous reports, it seems that at the present time a very successful form of treatment may be described as resting upon a *tripod—one* leg of which represents the immediate injection of an appropriate dose of antitoxin; the *second* leg of the tripod represents the thorough saturation of the patient's system with a *reliable* sulphide of calcium; while the *third* leg represents the frequent spraying of the throat and nose with peroxide of hydrogen.

The various complications which may arise, and the after tonic treatment, can be met with those remedies which every physician learns to look upon as his favorites.

Discussion by Dr. R. H. McConnell, New York.

Mr. President and Gentlemen:

I think the important thing about the treatment of diphtheria is the great question, what is the dose of antitoxin? That is a point which is being discussed, I think, as much as anything. There is a great difference of opinion. I think

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the question of size of dose depends greatly on the time you see the case. If it is the first day, give a smaller dose; in children with marked symptoms give a larger dose of antitoxin. I think the only thing to do if you have any doubt about the diagnosis, is to give antitoxin and take cultures afterwards. If at the end of six hours there is no improvement in the symptoms, the dose ought to be doubled. You may begin at three thousand units. I saw a case a few days ago that had to have eighteen thousand units the third day. I think another important fact is supporting the heart afterwards. Cases die, it is claimed, from the effect of the antitoxin. It is necessary to support the heart, as sometimes after the third or fourth day the patient may suddenly sit up in bed and fall over dead.

(After Dr. Kingsford.) Dr. McConnell.

Personally I do not think the antitoxin is the cause of death, but that the toxins are; but the question is often asked, especially among the poorer class of the city.

Discussion by Oscar C. Young, M. D., Charlestown.

Mr. President and Fellows:

These remarks recall to my mind a case of scarlet fever which I had a few years after I began practice. There was no doubt about its being scarlet fever. There were one or two cases of scarlet fever in the school, and three children in this family came down with the disease. The second child, a girl of seven or eight years, after being ill a few days, was severely burned on one leg by a hot-water bag placed in the bed by her mother. The burn produced no pain and the child was not conscious of its being done at all. Of course it was paralysis.

I looked up the matter of post scarlatinal paralysis, and found a record of only two cases; but I suppose there is occasionally such an occurrence; but the question arises as to whether there is not a mixed infection of scarlet fever and

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diphtheria. I believe that this was so in this case. The paralysis and the burn were the only unpleasant results of the case. The paralysis, as is usual following diphtheria, rapidly disappeared.

Discussion by Dr. Togus, Hooksett.

I had a case last fall in a house where they were visiting from Manchester, at Hooksett. They came to my office and wanted something for a child which had a cold, and I gave them something; and the next day they came and said the child was not any better, and I thought I had better go and see the child. They said no; they thought I better send something. So I did. The next day, Monday, they wanted me to go and see the child, as it was no better. The child was eight years old. From what I could see I thought the child had diphtheria. I got a bottle, then cleaned it up, wound up a little cotton, and took a swab from the throat of the child and put it in the bottle and put a paper around it and came to Concord immediately, and Dr. Duncan found it was diphtheria. I took antitoxin, and in three hours I gave him six thousand units, and had to hold him by force to get it into him. I gave his brother three thousand, and gave his mother three thousand; so it run up to quite a bill, of course; I was not going to pay for it myself; I did not know how well the people could pay. The way of it was, I had to give the boy that was so sick the antitoxin; he would not keep still, I had to hold him by force; he broke my needle and cut my fingers, but I was bound I would get it into him. The next day he was better. His brother who was older and the mother did not have it. The child got well, but he was practically paralyzed for a week. In all I gave him fifteen thousand units.

I was not prepared for this. Get a swab if you can, get it into the laboratory and get your antitoxin. For a man in the country it takes quite a little time to get it. I was well pleased that I did it. Although he was paralyzed for about two weeks, he is alive and well to-day. Do not hesitate to give antitoxin, as it will not injure any one; and if

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you find that the patient has diphtheria, you are on the safe side. If the patients do not pay, "as some are too poor to pay," the town is obliged to pay, as it comes under the same head as smallpox.

Discussion by Dr. James S. Bown, Manchester.

I wish to call attention to two points: First, Dr. Kingsford's statement that scarlatina was by some thought to be caused by the streptococcus. This opinion seems to me to be untenable for the reason that no streptococcal infection, whether it be erysipelas, felon, phlegmon or peritonitis, ever produces immunity to subsequent streptococcal infection; while the infection of scarlatina, as a rule, does produce permanent immunity. I believe that scarlatina is produced by an undiscovered infection which is usually *accompanied* by the streptococcus.

I have recently attended a case of scarlatina in a child, to which three brothers and sisters were exposed; two of them developed typical scarlet fever; but the third, although she has never had scarlatina, only showed the throat symptoms, but never any rash or other cutaneous manifestations. Her throat gave a culture of the streptococcus, but she had evidently only absorbed that part of the infection, and not the essential virus of scarlet fever.

The second point is this, that in the cases of laryngeal diphtheria, commonly called membranous croup, the patient dies from membranous obstruction of the larynx, and not from the poison of the disease. The production of death is mechanical and not toxæmic; therefore, in the bad cases, right after using an appropriate dose of antitoxin, we ought to introduce a tube into the larynx which will keep it open until the antitoxin has time to neutralize the toxæmia.

Discussion closed by Dr. Ober.

One of the physicians who has spoken, I think it was Dr. Kingsford, said I did not speak about using a small immunizing dose among those in attendance. I supposed it was the custom to always use an immunizing dose; I always do.

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PLACENTA PRÆVIA.

BY CHANCEY ADAMS, M. D., CONCORD.

"Man that is born of woman is of few days and full of trouble." Never was this saying more complete in its truthfulness than when applied to that period of a woman's life which dates from puberty to the climacteric. During this time the variety of conditions that complicate health and endanger life, traceable, directly or indirectly, to disordered function or pathological state of the genital organs, is *large;* yet those conditions that may be properly termed accidental, and in which exists the greatest danger, because of the suddenness of their onset and the rapidity of their development, are *few.*

The conditions thus referred to are characteristically found only in the puerperal state, and are as follows: Eclampsia, ruptured tubal pregnancy, inversion of the uterus, premature separation of the normally located placenta, post partum hemorrhage and placenta prævia.

Concerning the latter much can still be said that is of vital interest, not only to the medical profession but the lay subject whose life may, at any moment and without warning, be jeopardized to a most startling degree.

Although it would not be unreasonable to conclude that the history of placenta prævia dates back to the origin of the human race, yet its occurrence was not authentically reported until 1685, when Portal described it fully, both clinically and anatomically. Since this time many have recorded their experiences and set forth their particular views as to its causes and the best methods of meeting the emergency.

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During the long period of years antedating the invasion of the pelvic region by the gynecologist, and the establishment of operative gynecology as a distinct specialty, there appears to have been advocated but one course to pursue, although men differed somewhat in their methods of operative procedure. The supra-pubic route was then an unknown quantity, and attention was directed solely to rendering relief by the way of the vagina.

But since the day of Lawson Tait began to dawn a most radical change has occurred, and his views have been passed on until they are now possessed by many valiant supporters, some of whom advocate them to a degree of radicalism that to those of the older school appear quite astounding.

We thus find ourselves, at the present time, confronted by the representatives of two branches of the profession, viz., the gynecologist and the obstetrician, taking widely divergent views, and unwilling to meet on common ground.

But as time goes on experiences will surely work out new results, and these two factions, wide apart as they now may be, must necessarily throw off some of their radicalism and meet upon a harmonious level; because reason teaches that each case of placenta prævia must be decided upon its own merits, and not according to rule. Quite a variety of conditions conspire to make this assertion appear true, viz.: the three so-called varieties of placenta prævia—central, marginal and lateral; the stage of pregnancy at which hemorrhage occurs; the amount of anæmia present, dependent upon recent hemorrhage; the constitutional make-up of the patient; the presence or absence of a rachitic pelvis; fœtal viability or non-viability; primipera or multipera; hard and unyielding or soft and patulous os.

A centrally implanted placenta in a primipera whose cervix is hard and unyielding, and whose pelvis is either rachitic or normal, and whose fœtus is viable at term, surely offers a far different problem to solve than a laterally located placenta in a multipera with a soft and yielding cervix, a normal pelvis and a non-viable fœtus. Surely it would seem unreason-

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able for the obstetrician to complain if a Cæsarian section, even a Poro operation, were insisted upon in the former case, while the gynecologist would place himself in a questionable position were he to urge a Cæsarian section in the latter. Yet men can be found to-day who are worthily bearing the honors which due merit brings to the gynecologist and obstetrician respectively who strenuously insist that the treatment peculiar to their own particular specialty be employed in nearly all cases. Holmes, of Chicago, claims that no obstetrician of repute at the present day favors Cæsarian section for placenta prævia. Yet Morris and Lamphear have performed hysterectomies at the fourth and fifth month for miscarriages, when severe hemorrhages were present, in apparently doubtful cases of placenta prævia.

When men whose standing is high in their respective art differ so widely, what is the natural conclusion? Either that they have become hypnotized by the fruits of their own victories in perhaps carefully selected cases, or that their skill fails them when they attempt to invade the field of the other specialty. The truth of the latter part of this statement seems true when we consider the results of Tait, according to his own words, when he asserts that the maternal mortality is 50 per cent. Brilliant operator that he was in his own specialty, when he invaded the field of obstetrics, which he had purposely neglected for thirty years, he found that his results were far from creditable.

The entering wedge that opened the way to the gynecologist into the treatment of this class of work was evidently the high mortality rate of the mother in cases unfavorable for delivery via vaginæ, whether at term or not, and the presence of a viable child near or at term.

Until the removal of the lid from the abdominal and pelvic cavities was safely accomplished, the above-named class of cases continued to baffle the highest degree of obstetrical skill. This, I think, was more particularly true in the light of fœtal mortality. Very naturally, then, men turned to some other way to save life, and the rights of the child made its

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strongest appeal to the heart of man when the supra-pubic route was found to offer a new hope. And herein lies the strongest argument in favor of Cæsarian section, and the position taken by Tait, Donaghue and Dudley surely have an appealing force when they urge the latter treatment when the child is viable at term and the mother in good condition.

If, on the other hand, that other class of cases which, I believe, far outnumbers the above-named, is to be considered, I think the profession would do well to wait a longer time, until the gynecologist can prove more conclusively than has yet been done that the supra-pubic route offers a better chance. Because he has yet to show that in a given case of a multipera, with normal or abnormal pelvis, with placenta centrally, marginally or laterally located, with soft and easily dilatable cervix and a nonviable fœtus, with the condition of the patient good or bad, he can offer to that patient any better chance than the obstetrician can do by his orthodox method. That being true, why then add to the danger that already exists the increased risk from sepsis, hemorrhage and shock? And these surely are no small considerations when dealing with Cæsarian section for placenta prævia. Sepsis via vaginæ, hemorrhage from atony of the uterus, and shock from the operation added to shock that already exists from acute anæmia that is present from hemorrhage, which in the majority of cases precedes the coming of the physician, are conditions to be carefully weighed before resorting to section.

The final decision of this question will undoubtedly be determined upon the basis of maternal and fœtal mortality rate. To this end as yet statistics offer but little relief on account of the variety of conditions that enter in.

Owing to the nature of placenta prævia many cases will continue to occur under the most unfavorable circumstances. It being essentially an emergency condition, cases are bound to appear when and where even the highest skill would fail to save.

According to certain statistics placenta prævia occurs in a varying proportion, all the way from 1 in 200 to 1 in 1,000

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cases. Müller states that out of 876,432 cases it occurred once in 1,078. Out of 105,935 cases, collected from 1,000 physicians and maternity hospitals, Gillette reports 216 cases, 1 in 481; 34 mothers were lost, a death rate of 15⅓ per cent.; 96 children lost, a death rate of 44⅓ per cent.; there were 88 cases of centralis; 20 mothers were lost, death rate, $22\frac{8}{11}$ per cent.; 66 children lost, a death rate of 70½ per cent. Of the remaining 128 cases, 14 mothers were lost, a death rate of 31½ per cent. None of the mothers died prior to the seventh month. Another authority states that out of 1,029 cases treated by celebrated physicians there was a maternal death rate of 3.3 per cent. Reynolds shows an immediate fœtal death rate of 33⅓ per cent., and an ultimate of 50 to 75 per cent., in Cæsarian section for placenta prævia. Thus statistics vary. I think it is now conceded that Cæsarian section when done early will save more babies, but undoubtedly increase the risk to the mother; but when you consider that 10 per cent. of babies born alive live but twenty-four hours, and nearly 25 per cent. die within the year, and 52 per cent. before fifteen years, as is stated on good authority, how much encouragement is thus offered, except in carefully selected cases, to submit that mother to any increase of danger? I am sorry to say that I can bring but a very limited personal experience into this paper, having had but one case in my own practice. She was a multipera, thirty-eight years old, had borne three children, and had had one miscarriage; youngest child five years old. When about three months pregnant she began to flow a little, lasting a few days. For five weeks she was free from any hemorrhage, when it started up and continued moderately about three weeks, when it began to increase. During these weeks of moderate flow she was taking medicine which appeared to affect her condition favorably for the time. When her flow began to increase I put her to bed at home, where she remained two weeks, during the latter part of which time, about two days, I kept her vagina tamponed. Hemorrhage continued, and she was moved to the Margaret Pillsbury General Hospital, where

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vaginal tamponading was continued for four days, for the purpose of softening the cervix, it being very rigid, and of restraining hemorrhage until the former could be accomplished sufficiently to warrant an attempt at rapid dilatation, which her condition clearly indicated was already necessary. At the end of this time, under ether anæsthesia, I found no difficulty in passing one finger at a time until my whole hand was admitted through the cervix. I found the placenta centrally located, and in my effort to reach the fœtus broke through it at about its middle. The head was the first part that met the grasp of my hand, and fœtus and placenta were rapidly delivered. Complete uterine inertia resulted, and the hemorrhage was profuse. As rapidly as possible I packed the uterus and vagina from fundus to vulva with sterile gauze. After putting a good quantity of hot saline solution under her breasts, and injecting nitroglycerine, strychnine and ergot she was placed warmly in bed and watched closely. While she was on the table after delivery she became blanched, and her pulse 150 and very weak. I thought she would never rally, but she did, and to-day is well and strong. It was afterwards proven that in addition to hemorrhage from the placenta site she had lost much blood from a right lateral tear of the cervix.

On account of the hasty delivery and the urgency of the after treatment, this laceration was undiscovered until a week later, when it appeared upon the removal of the vaginal tampon. The laceration was deep, and must have involved the uterine artery or an important branch.

A very surprising and gratifying feature of this case was the manner in which the os softened and relaxed during the four days of tamponading, changing what at first appeared to be a difficult procedure into one of comparative ease. I am indebted to Drs. Walker and Sullivan for their able assistance in this case.

To summarize, it appears that in the minds of those authorities who occupy a middle ground, and therefore are less radical, that Cæsarian section for placenta prævia has its indications, but only to a limited degree, viz.: in those cases where

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there is a viable child at term, but little hemorrhage, rigid os, placenta centralis, and mother and child in good condition; in other words, when conditions are favorable to save the child as well as the mother; that maternal mortality is increased and fœtal mortality somewhat lessened by section; and that in quite a proportion of central, and in all cases of marginal and lateral implantation, the vaginal route offers less risk to the mother and nearly as good a chance for the child.

However, before a perfectly satisfactory conclusion can be arrived at, statistics must be more exact, like conditions should exist when comparisons are made and many cases tabulated. Comparisons are of but little value when made between cases cared for in remote localities amidst unfavorable surroundings far away from surgical aid, and those fortunate enough to be in or near hospitals where prompt and efficient service can be rendered before valuable time has been lost.

Discussion opened by C. R. Walker, M. D., Concord.

Mr. President and Gentlemen:

I do not feel qualified to discuss this paper, but I have seen in consultation some of these cases. I am very glad to say that I have been fortunate enough not to have had in my own practice a case of placenta prævia. We seem to be in a transitional stage in the treatment of this condition. The importance of the question is being brought prominently to the front, as we all know from the journals and text-books.

In these days of sepsis and antisepsis we cannot but feel that at least one of the greatest dangers to the mother is infection, and that the greatest care should be exercised by us all in the use of the tampon, as the danger seems to be as great from sepsis as hemorrhage. Some writers go so far as to say that Cæsarean section only should be considered, and that all the appurtenances should be removed at the time of operating. Some of the advanced men are taking that view, which I think is rather an extreme one. Some obstetricians are beginning to advance the thought that the question of

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always making frequent vaginal examinations is most important and should be more thoroughly studied.

Most of our pregnant cases come simply as ordinary patients for consultation. To-day we do examine the urine, but no palpation of the uterus is regularly made to determine if we have a placenta prævia. Most of our diagnoses are made from the hemorrhage, not from examinations. One man tells you that vaginal auscultation is of assistance, others that it is valueless. I hope some physician will explain how by vaginal examination one can be absolutely certain of placenta prævia in some form. In hospital work, of course, examinations are constantly made. I remember one case showing where auscultation was of great value. I was listening to a fœtus in utero and was told that such and such heart sounds were to be heard. I could not hear them, the heart's action had stopped and only by rapid delivery was the child resuscitated. One who has a case of placenta prævia is like a man living in a volcanic country, for trouble may come any instant. It is our duty to instruct our patients that they must come to us and must be examined for their own safety. A majority of them are normal, but like the surgeon at St. Louis who said "that eighty per cent. of all cases of appendicitis will get well without treatment, twenty per cent will not. I operate on everything." Therefore it seems to me that we should watch all cases of pregnancy closely, and by educating the people as to the necessity of frequent examinations we can hope to reduce the mortality of placenta prævia by being forewarned and therefore forearmed.

Discussion by Dr. T. M. Togus, Hooksett.

Mr. President and Fellows:

I will state for the benefit of the doctors a case which I have had which may be of some use to some of the doctors. I have seen only two cases in all my practice. The first case was my own, the second was in consultation.

I was called about five o'clock to a young woman who had

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had a child a year and a half ago, and when I got there it seemed she had been flowing most of the night. When I made an examination, the first thing I got was a rush of blood about as big as my arm; then I realized that there must be something done quickly or else the patient would bleed to death. I put my hand in and found the placenta coming out; there was a dilatation about as big as the head of a child, and I pushed my hand in, and the blood came like a torrent. I felt the child, and put my left hand on the abdomen, and in ten minutes or less the blood quit flowing. When I broke through the placenta the placenta came first, then the child was delivered. I doubled up my fist and pushed it in the uterus. I had not time to send for assistance. With the fist doubled up into the uterus, and pressing against the abdomen with my left hand, the blood ceased flowing and she revived. Every time I let go of the uterus with my left hand it would start flowing again; and perhaps if I had stayed there with my left hand on the uterus and my right on the os, I might have saved the woman's life. I thought she was better; she revived; and all at once the hemorrhage came and she died in twenty minutes. You should keep one hand on the outside and your fist doubled up against the os until you can get some contraction that will stay there. I could feel the hemorrhage come right from the os instead of from the fundus.

If you ever have a case you should keep contraction from outside, and not let go until you get an assistant. Packing the vagina with absorbent cotton is a great help in arresting hemorrhage, and it should be done if possible.

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THE MODERN CONCEPTION OF THE SYMPTOM-COMPLEX, HITHERTO KNOWN AS FRIEDREICH'S DISEASE.

BY ARTHUR WILLARD FAIRBANKS, M. D., BOSTON, MASS.,
ASSISTANT PHYSICIAN, DEPT. FOR NERVOUS DISEASES,
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This paper cannot be said to be a consideration of Friedreich's disease, if by this term we mean the affection described in the text-books; for it is more than this. It is a consideration of a symptom-complex of which the cases described by Friedreich and his followers were but one type or one stage.

I take the liberty of quoting a few lines from a previous paper of mine on Central Ataxia in Childhood, and this will indicate that I believe that the previous conception of Friedreich's disease must be changed and greatly broadened.

"The clinical characteristics of this affection, stated briefly, are: Muscular inco-ordination commencing usually in childhood, and, as a rule, first affecting the muscles of the lower extremities, thence extending to the upper extremities, and to the muscles of the trunk, head, larynx, tongue and eyes; slowness of muscular response to volitional impulse; swaying, unsteady gait; slow, hesitating or deliberate speech, sometimes of nasal character and occasionally explosive; nystagmus; oscillation or tremor of head, body or extremities; and certain involuntary movements, which may or may not be of choreiform character, and which may occur independently or may be associated with volitional intended movement of some other part of the body; lateral curvature of the spine; deficient energy in carrying out voluntary movements; and in

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an advanced period of the disease, paralysis, muscular spasm and contractures.

"To this symptom-complex may be added, during the course of certain cases, various other symptoms not sufficiently invariable to be considered characteristic, but, nevertheless to be regarded as inherent, although less common phenomena. Among these may be mentioned vertigo, headache, optic atrophy and impairment of pupillary action and of the movements of the ocular muscles, apathy of facial expression, a tendency to involuntary and unprovoked laughter, loss of muscular tone, sensory disturbance, peculiar deformity of the feet, trophic changes in muscles, and very rarely interference in the action of the sphincters and trophic changes in the skin.

"Certain other phenomena must be regarded in the light of complications, since they are clearly due to involvement of those parts of the central nervous structure, primary affection of which would produce a clinical picture totally different from the one we are considering.

"Such is the occurrence of psychical phenomena, depreciation of intellectual power, or epileptiform attacks."

The interesting affection comprehended in this symptom-complex is as varied in its clinical manifestations, in the collective grouping of its multiform symptoms, and in the insidious onset of its early stages, as any other disease of the central nervous system, with the exception of insular sclerosis, and yet it is well-defined and characteristic, when it has reached a certain stage in its development, if the characteristic features are considered *collectively* and not individually, and especially if the history of the manner of their onset and progress is known.

The multiplicity of its clinical phenomena is dependent upon the relative degree of activity and duration, and therefore on the extent of the process in the central nervous structure of the individual case.

The eventual unfolding of a symptom-complex presenting a definite and characteristic clinical picture is due to the fact that certain distinct tracts in the central nervous structure are invariably diseased.

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The involvement of these definite portions of the central nervous system produces typical resultant clinical phenomena. In other words, this affection is a systemic disease, in the neurological sense of the term, involving that system of nerve centres and associated tracts having to do with the coördination and control of muscular movement and muscular tension and the maintenance of the equilibrium. Naturally the completeness of the clinical picture depends directly on the duration, activity and extent of the morbid process within this system of nerve cells and tracts.

Not only is this the case, but it is a fact that the disease does not at any one time really present a complete, though it may be a perfectly typical, picture, because as the process advances some of the earlier phenomena are masked or completely obliterated by the phenomena of the later stage. So that the ideal picture of this interesting affection can be drawn only by a life history of the disease. In other words it is not the grouping of symptoms at any *one* period that *alone* portrays for us the characteristics of the disease, but it is the gradual *unfolding* of the symptom-complex, especially its early stages, quite as much as the complex itself, that enables us to accurately describe the affection and assign to it its proper place in the catalogue of disease. To the failure to recognize this fact is due the chaotic confusion in regard to the diagnosis and classification of cases that has prevailed in the minds of diagnosticians from the classic day when Friedreich described his cases to the present time. Friedreich himself erred when he assumed that the features presented by his cases formed the typical picture of the disease. All of his patients were in an extremely advanced stage of the affection when seen by him. Of the six cases only one was able to stand or walk and he only with support. This is the *terminal* period when many of the striking phenomena are obliterated. Not only was this fact not fully appreciated by Friedreich, but infinitely greater harm was done by those who followed him in describing the disease. Ladame and others, especially Marie, were responsible for the establishment of an arbitrary standard to which they demanded that all cases conform, a

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standard based on observation of a few cases in a particular stage of the process. They assigned all other cases to a different category, notwithstanding the fact that most of them varied in only minor features from the artificial standard they had created. On this account we have the terms hereditary ataxia, cerebellar ataxia, and finally the title applied to cases described as Friedreich's disease. It is my belief that these are but varying types of one and the same disease and seen in various periods of the course of the morbid process. This opinion, which I expressed before the section on diseases of children at the Portland meeting of the American Medical Association last summer, I propose to substantiate at some later date by publishing the results of a comprehensive study of all available cases, including several of my own.

The cases originally described by Friedreich had their apparent origin at about the period of puberty. It was therefore for a long time assumed that a case commencing at any other time could not be Friedreich's disease, and this idea prevailed for many years, but the disease in a great majority of instances begins in early childhood, and it is the exception to have it occur at, or after, puberty. It was required that the knee jerks be absent, mainly because they were absent in Friedreich's cases; and this idea is almost universally expressed in the text-books at the present time. But it must be remembered that Friedreich's patients were all in a very advanced stage of the disease, by which time the process is pretty sure to have involved the territory of the reflex arc. Five of my own cases were seen very early in childhood, and in four of these the knee jerks were increased, in one considerably diminished when first seen, and at a subsequent date abolished. In another case, recently seen in consultation with Dr. William E. Fay, the patient being a girl of fifteen years, in whom the disease apparently began in her ninth year, the knee jerks were very greatly increased. The first case of this affection that I ever saw was in Senator's clinic in Berlin, in a boy ten years old, in whom also the knee jerks were very much increased.

In addition to the cases which have come under personal

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observation, I have notes from the literature of many other cases in which this patellar reflex was present. We must modify our idea of the status of this reflex in this disease. We may say that in the early stage of the affection the knee jerks are usually present, very frequently increased, only occasionally absent; in a later stage they are usually greatly diminished or absent, sometimes, however, preserved or even persistently increased. The condition of the tendon reflexes therefore is solely a matter of the duration, location or extent of the lesion in the tracts of the central nervous structure affected by the disease, and the presence or absence of the reflex is of no differential diagnostic value in this affection, and merely indicates whether the process has or has not involved certain definite portions of the nervous structure. I emphasize the status of the knee jerk more than its importance really deserves because it has for years been a bone of contention between the advocates for and against the maintenance of Friedreich's original type.

Then for a long time it was thought that the disease should show a pronounced hereditary or family prevalence.

It is not necessary, however, and a large minority do not present such a history. There must be a beginning for everything and many of these initial cases might be the beginning of a family or hereditary disease if the individual were not too severely affected by the time the marriageable age was reached, and if they married and had children. Most of the cases by that time are so pronounced that they are not likely to marry, and if they do are still less likely to have many, if any, children. It is the cases that begin late, or those of extremely slow progress, that are prone to show the disease in their descendants. It is thought by many, and even stated in some text-books, that the cranial nerves, especially the optic, are not affected in this disease. Any of the cranial nerves may in fact be involved, the most frequently affected being the third, the sixth, the seventh, the optic and the twelfth.

As the most striking feature of the symptom-complex is the affection of the active motor-function, this disease does not lend itself well to illustration by stationary photographs. It is

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hoped that we may some day be able to portray its most remarkable and characteristic features by the cinematograph. I have here some photographs, however, which I wish to show you which illustrate well certain interesting features of our symptom-complex.

In considering the pathological changes in the central nervous structure responsible for the clinical symptoms of this disease, we have first those cases that, during life, were thought to be instances of Friedreich's disease, and in fact did correspond fairly well with the cases described by him; second a small series of cases clinically described as cerebellar ataxia and hereditary cerebellar ataxia, the latter being the name given by Marie to the affection, varying considerably from the original Friedreich type and at first sight apparently constituting a different disease; and finally between these two types a large number of cases that do not correspond exactly to either of the first two classes. If, however, we study carefully all of these cases we shall find that the clinical variations are not so pronounced as at first sight appears and a perfect series of cases can be found, merging one into the other, until we have merely a series of gradations in the symptom-complex of what is, in the writer's opinion, one and the same disease. When we come to study the pathological changes found in the cases that have come to autopsy we are, I think, even more justified in this belief. The prevailing morbid change is a degeneration of the nerve tracts in the posterior columns of the cord and an atrophy and diminution in number of the ganglion cells of the columns of Clarke in the grey matter of the cord, and a degeneration of the fibres of the direct cerebellar tract in the lateral region, which is unquestionably secondary to the destruction of Clarke's cells. These columns are affected in varying degree in the different cases, in some apparently in the cord alone, in others extending to and involving the medulla and the cranial motor nerve nuclei, and in others the tracts from the medulla to the cerebellum, and associated with atrophy of the ganglion cells of the cerebellum. The posterior nerve roots in the cord are also usually involved, and not so very infrequently also the

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peripheral nerve trunks. It will be noticed that the tracts and cells, characteristically involved in this disease, belong to a well defined system in the central nervous structure, whose function it is to interpret and to assist in maintaining the harmony of action of the muscles and the equilibrium of the body and its parts. In addition to this well-defined system involvement is the not infrequent, though usually late, involvement of the pyramidal tracts and the occasional implication of the optic nerve; both outside of this system in a way, but, nevertheless most closely associated with it in the control of the equilibrium and harmonious muscular action.

It is obvious that the character of the symptom-complex of this disease depends entirely on the distribution (and hence upon the duration and intensity) of the degenerative process in this system of nerve fibres and cells in the central nervous structure. It is obvious that a very considerable variation in the individual clinical phenomena must of necessity occur, but that such individual variation does not constitute a different clinical disease so long as the symptoms in the aggregate clearly indicate an affection of this systemic character.

On this basis, therefore, the modern conception of this disease should include all cases whose clinical features indicate involvement of the cerebello-spinal nerve centres and tracts, concerned in the evolution and control of coördinate muscular action and the maintenance of muscular tension and the equilibrium of the body.

It is essentially a *cerebello-spinal atrophy* and sclerosis, probably supervening on a developmental insufficiency, either in structure or in the inherent vitality of the nerve cells and fibres affected.

If the term Friedreich's disease cannot be employed in a sense not synonymous with its old and restricted meaning, then it will be better to drop the name and apply some more comprehensive title to the affection.

Then the many cases at present without definite status in the catalogue of disease will receive their proper assignment and classification.

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CÆSAREAN SECTION, WITH REPORT OF CASE.

BY JAMES S. BROWN, M. D., MANCHESTER.

The operation of Cæsarean section, while of the most ancient lineage and sanction, and which possesses the unique advantage of saving from death two human lives if opportunely and correctly performed, has been allowed to fall into a state of practical disuse by the obstetricians and surgeons of New Hampshire.

I have made many inquiries amongst the physicians of the state, and have been able to learn of the following cases only. If other Cæsarean operations have occurred I would be glad if those who know of them would speak of them in the discussion.

Such operations in this state which I have been able to collect are the following: About thirty years ago, Dr. Hersey, of Manchester, operated, saving the mother, but the child died or was dead at the time of operation.

Sometime later Dr. Grove, of Whitefield, had a case in which the child survived but the mother died.

The next case of which I know occurred in Manchester, in an extremely contracted pelvis and septic case, in which the child was extracted dead and the mother died of peritonitis.

My own case occurred about three years ago, and both mother and child are living and well.

Dr. Gile has performed this operation twice, once in New Hampshire and once in Vermont. The operation in New Hampshire occurred about one year ago, and both mother and child are alive and well.

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Drs. Beaton and Drake, of Franklin, had one case, equally successful, at about the same time.

The statistics thus far quoted are very unfavorable, and would naturally condemn the operation unless analyzed more carefully.

You must realize that the majority of the above-mentioned operations were performed in the pre-aseptic era; and as a last resort after forceps and version, etc., had been repeatedly tried ineffectually.

Cæsarean section must not be used in the same way as a drowning man clutches at a straw; if possible, the physician ought to know that the labor is to be extraordinarily difficult, and then, if necessary, undertake Cæsarean section in a way carefully prearranged beforehand.

It is my belief that a large number of women and children die or are severely mutilated each year on account of the fact that difficult or impossible procedures are adopted in place of Cæsarean section.

It is to be advocated in proper cases, which are far more numerous than is usually supposed, upon several grounds:

1. As a life-saving measure for both mother and child.

2. For religious considerations, as the Catholic church absolutely forbids the sacrificing of the life of an unbaptized infant for any reasons whatever, even to save the life of the mother.

3. For sentimental reasons, in that it avoids the repugnant spectacle of the mutilation and death of a living child.

4. For the very practical reasons that it saves the mother all the pain and danger of a long labor, as she merely takes ether, and in twenty or thirty minutes of unconsciousness the labor is completed.

The mortality to-day in ordinarily good hands is five per cent., or in the best hands much lower, and it may be performed at the operator's convenience and in any house where ordinary surgical cleanliness may be made to prevail. Cæsarean section has been too long held up as a bogey by the

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medical profession; if practiced with forethought and careful attention to a few rules, it is an extremely successful and easy operation.

The history of this ancient operation is very interesting. It derives its name from Julius Cæsar, who was supposed to have been delivered in this way; but the fact is that he entered this world by the same well-worn route by which I suppose all of you came. The first mention of this operation in medical literature occurs in 1581, when François Rousset collected the records of fourteen successful cases; but upon hearsay testimony the earliest successful case occurred in 1610 by Trautman. The child lived, but the mother died three weeks later of embolism. The earlier mortality was extreme. In 1888 there were reports of one hundred and fifty-three cases in the United States, with a maternal mortality of 63 per cent. In 1873, in the Paris Lying-in Hospital, there had been fifty cases in the previous eighty years, with no maternal recoveries. In contrast to these results obtained in the pre-aseptic era, and in the days when lying-in hospitals were loaded with pyogenic bacteria, it is interesting to note that in the United States, in 1887, there were collected nine cases of women at or near term who were gored by bulls and the uterus opened, of whom four mothers and four children recovered; and of six cases of women who insanely opened their own wombs by Cæsarean section, five recovered.

INDICATIONS.

The indications for the performance of this operation will naturally be divided into two groups by the decision as to the existence of a living or a dead child. In the latter case the only indication is the impossibility of any other mode of delivery. If the child is living and there exists grave doubt as to the possibility of the birth of a living child through the natural passages, the balance of judgment should lean to the performance of section and to thereby insure the life of the baby, although of course no harm can ensue if labor is allowed to progress for a reasonable length of time to see if nature can overcome the difficulty.

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As far as the measurements of the maternal pelvis are concerned, usually only the antero-posterior need be considered. If in measuring by the forefinger from the notch below the symphysis to the promontory of the sacrum the length is found to be 9 cm. or below, Cæsarean section is the operation of choice, although, as above stated, in doubtful cases labor may be allowed to proceed to see what nature may accomplish. And on the other hand in pelves of that measurement or even above, the history of very difficult previous labors may determine that section ought to be performed. The above clause is very important because it is in just these doubtful cases that the most damage is done by a temporizing or waiting policy. Many a woman who after thirty-six or forty-eight hours' labor and agonizing pain could give birth to a dead, deformed or idiotic child, perhaps, would far better be delivered by Cæsarean section with a painless and short labor and the certainty of a living and undeformed child by Cæsarean section performed many hours earlier.

Another indication is the presence of a tumor of sufficient size to obstruct labor in the lower uterine segment, which cannot be pushed above the brim of the pelvis. In this case the Porro operation of hysterectomy would of course be indicated. In case of rupture of the uterus with escape of the child into the abdominal cavity, Cæsarean section ought of course to be performed, but I might add it should be done before any such calamity has been allowed to take place. In certain cases of cicatricial contraction of the vagina it is also the operation of choice, but it is extremely rare that such a condition would render the operation advisable.

TIME.

The operation is best performed at term as nearly as that can be calculated, but to suit the operator's convenience labor may be started by the insertion of a bougie into the uterus. The presence of a dilated cervix and unruptured membranes is an advantage but not a necessity.

PREPARATIONS.

Shave the parts and scrub well with soap and water and

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bichloride 1-1000. If there is time give a cathartic and follow by an enema; if time is lacking give the enema only.

PROVIDE

12 large sterile gauze sponges.
12 sterile towels.
12 hæmostats.
1 knife.
1 pair scissors.
1 needle-holder and needle.
1 mouse-tooth forceps.
Some 20-day chromicized catgut.
Some fine silk.

I give a complete and itemized list of the instruments for this operation because it is getting to be the fashion for many operators to get out an unwieldy and unnecessary array of instruments and other accessories for surgical operations.

The position of the patient should be flat on the table with knees flexed over the foot of the table.

ASSISTANTS.

The etherizer.

One assistant to perform the usual duties of surgical assistant.

A second assistant to stand at the foot of the table facing the pelvis of the mother and as soon as the abdomen is fully opened to grasp the uterine and ovarian arteries and to hold and compress them sufficiently to shut off the uterine blood supply until the operation is completed. At term these arteries run by the sides of the uterus nearly vertically in the broad ligaments and with surprising ease they may be held and the bleeding almost entirely controlled.

One other assistant is needed to take charge of the child and resuscitate it if necessary.

In the performance of the operation no special surgical dexterity is needed, but it is advisable to exercise a little fore-

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thought as to the successive steps of the procedure so that each may be undertaken in its logical order and sequence, for in no surgical operation is it more important that no time be wasted unnecessarily.

TECHNIC.

Cut deliberately one third above to two thirds below and to the left of the navel. Be careful not to cut the uterus in the first cut. It lies surprisingly near the parietes. The second assistant then grasps the arteries and controls the uterine blood supply. Incise the uterus longitudinally from fundus to white line indicating reflection of bladder peritoneum. Make it long enough for the head to come out easily. Cut slowly through the uterine tissue and if the placental villi come into wound do not cut the placenta but separate it from the uterine wall with the finger. Grasp the child by foot always, never by hand as that would make a shoulder presentation. If the head is impacted in pelvis have the third assistant push up upon it through vulva.

When the child is delivered clamp the cord in two places and cut between to save time. Have the nurse give the mother two hypodermics of ergotole. Massage the uterus for a minute and in the meantime squeeze off the placenta if necessary and take away the membranes. Separate all the membranes you can quickly, but do not waste too many minutes over small pieces. If the uterus is septic enlarge the abdominal incision and deliver the uterus before incising it; if not, have the assistant press the abdomen closely to the uterine walls.

The principal consideration in the performance of this operation is the control of the hemorrhage. In regard to this matter we must remember that the parturient woman loses in a perfectly normal labor about one pint of blood and is none the worse therefor and that she can, during the birth of a child, lose much greater amounts of blood with safety than at any other time or in any other way. Granting that this be so, it is none the less necessary that we should lessen the hem-

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orrhage to the utmost. The pregnant uterus and its contents are so extremely vascular that an astounding flow of blood may occur, especially if the placental sinuses are cut into and if the arteries are not properly controlled by the assistant whose sole duty is to attend to this matter and this alone. This assistant should grasp both broad ligaments low down and closely enough to catch each uterine artery between the fingers and thumb.

After the delivery of the child, placenta and membranes, the uterus should be kneaded for a moment to restore contraction, and then the sutures (which are the prime hemostatics) rapidly introduced. Two layers should be used, one of 20-day chromicized catgut to include the whole thickness of the uterine wall, and a second layer of fine silk Lembert sutures which turn in the peritoneum over the incision. The peritoneum is then cleansed of blood clots, the omentum is brought down behind the uterus and the abdominal wall is sutured in any way which suits the individual operator the best. The operation should be performed quickly but not hastily and this result is best attained by a careful forethought as to the sequence of each step from beginning to end. Usually twenty or thirty minutes is enough time from start to finish.

The after treatment with regard to nursing the baby and diet of the mother are the same as after normal labor, except that the mother's diet should be restricted to small quantities of water for the first twenty-four hours. One daily vaginal douche of creolin is indicated, but intra-uterine douches need not be given unless there is evidence of the retention and decomposition of membranes or clots, in which event the usual non-poisonous uterine injections may be employed.

I have had one personal case which, so far as I know, is the first case of Cæsarean section successful for both mother and child that has occurred in New Hampshire.

Mrs. M. has been a patient of mine for about eight years. She came to me about six years ago and asked my advice as to whether she was physically able to marry, and after a somewhat hurried examination I told her she could do so.

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She had her first confinement four years ago, and was attended by two good practitioners who found it necessary, in order to effect delivery, to do a podalic version, and then had to mutilate the head in order to extract a dead child. In the course of this she was badly torn, and had to go to a hospital and was sewed up, but the stitches did not hold and the laceration still exists.

A little more than a year after, she again became pregnant, and consulted me. I measured her pelvis with the following results:

Transverse measurements, normal.

External conjugate, 19 cm. instead of 20¼.

Internal conjugate diagonal, 11 cm. instead of 12½.

True conjugate, estimated 9 cm. instead of 11¼.

I advised her to have premature labor produced at eight and one-half months, but I heard nothing more from her until one night they telephoned to me that she was in labor. I sent Dr. Milliken to attend her, and the labor proceeded for thirty-six hours without engagement of the head or rupture of the membranes, although there was full dilatation of the cervix. Dr. Milliken finally notified me that he believed labor per vias naturales was impossible, and I had her taken to the Sacred Heart Hospital, and after about one hour's preparation we performed the operation.

We did not have the assistant who should have attended to compressing the broad ligaments and that alone, and as the placenta lay under the uterine incision, and we were unfortunate enough to wound some of its sinuses, the hemorrhage was very excessive and even terrifying for a few moments, but ceased upon the delivery of the child and separation of the placenta. Convalescence of mother and child was normal, except that the mother had a small rise of temperature for a few days due to small pieces of membrane left in the uterus. I gave her the following intra-uterine douche daily as long as she had fever:

Tincture of iodine, 1 ounce.

Potassium iodide, 1 dram.

Water, 3 quarts.

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After four or five of these the temperature remained normal, and she always nursed her baby after the first twenty-four hours. The child was a male, and had probably gone over term about two weeks, and weighed nine pounds fourteen ounces naked.

From the measurements of this woman's pelvis one would think that she could give birth to normal-sized babies by the natural way, although we would expect the labors to be very difficult, but her children have both been very large, and in addition there is probably some projection high up on the posterior wall of the pelvis which prevents engagement, but which cannot be felt. The child is alive and well, and rejoices in the name of Michael Cæsar McGuinness.

In comparing this operation with some others in which to a certain extent and limit the same indications may extend, we can say that in the merciful light of modern surgery symphiseotomy is obsolete, because it mutilates and cripples the mother without furnishing adequate advantages to the child. Craniotomy in the presence of a living child is often the cause of sepsis, and always a source of danger to the mother, and is murderous to the child, and is opposed by all religious, sentimental and psychical considerations of the physician's art and science.

The operation of Cæsarean section is to be seriously considered in primiparæ whose pelves indicate great difficulty in spontaneous delivery, and in all multiparæ who have had extremely hard labors with dead, deformed or imbecile children. It is painless and quick for the mother, the child's life ought to be absolutely safe. From the standpoint of the surgeon it has many advantages in that it does not demand great technical skill, its performance is easy, and it may be done at a time selected by the surgeon, and therefore convenient to him and his assistants. The only prerequisites are that careful asepsis must be maintained in examinations of the woman and during the operation, and that all steps must be thought out and planned beforehand.

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Discussion opened by C. W. Milliken, M. D., Manchester.

Mr. President, Ladies and Gentlemen:

Dr. Brown has covered the field pretty thoroughly, but there were one or two points that will certainly bear repetition. One of the most important things, as Dr. Brown said, is to determine beforehand the liability of having to perform the operation, and of course while modern obstetrics means thorough asepsis, you will realize in a case where Cæsarean section may have to be performed, that extreme care should be taken in all examinations. I take some credit to myself in this case in that I made but two examinations, and those under the best possible aseptic conditions. Another very important point is that no attempt should be made to extract the child with instruments, lacerating tissues and exhausting the mother, as well as increasing the dangers of sepsis. If such attempts have been made, I consider this operation is contraindicated.

Discussion by Dr. R. J. Graves, Concord.

I have been an assistant in several interesting Cæsarean sections. One of these was the patient's second delivery by this method, another the third. This latter woman has since had her fourth successful operation. A somewhat unique feature of the case mentioned first was that at the second operation the abdominal cavity was not opened, the uterus having become adherent to the anterior abdominal wall as the result of a stitch abscess following the first operation. These cases illustrate the comparative safety of this method of delivery in the hands of properly qualified men.

Discussion by Dr. I. G. Anthoine, Nashua.

I had quite an interesting case to me some three or four years ago. I do not know as it is hardly worth while to report, because I did not take any measurements. It was a case of deformed pelvis; the antero-posterior diameter must have been very short. I was called when labor had appar-

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ently commenced, but it lingered along some days before it was well started. In making my examination I at once discovered that there was a flattening of the pubic bones, and I presume if I had heard this paper I should have had Cæsarean section performed; but I consulted a local physician in regard to it, and we decided to let the case go on, and if necessary take the child by pieces. When labor was well advanced I called the consulting physician, and we let it advance as far as we thought it could without help, and then chloroform was administered and I applied the forceps; and as I did not expect the child could be born alive, I used quite a good deal more pressure than I usually do, and when the head was down to the inferiœ strait I canted the forceps so that the occiput came to the left anterior position, and succeeded in bringing the head under the pubic arch, and the child was born alive and lived, and the mother got along well. I mention this to show what an extremely small space a child can be brought through.

Discussion by Dr. A. A. Beaton, Franklin.

Mr. President:

I feel somewhat disappointed at not hearing Dr. Brown's paper. Knowing it to be the sixth number on the program, I thought that I would be on time to hear it.

I can simply add another case to the list, which was operated on by Dr. Drake, of Franklin, at which I assisted.

I am sorry that the Doctor is not here himself to tell you about it. I was called in consultation with the Doctor about a year ago to see this case.

She gave a history of being confined about a year ago, three days in labor. The doctor who attended her had considerable difficulty removing the child in sections.

Examination revealed a very small pelvis, especially in the antroposterior diameter. We decided that Cæsarean section offered the best chance for mother and child, but decided to delay it to as nearly full term as possible.

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The operation was performed about six days before full term, under the most careful antiseptic precautions.

The uterus was delivered through the incision, a rubber dam being placed around it, to prevent blood escaping into the abdominal cavity. The placenta was then located and carefully avoided when making the incision through the uterus.

We got considerable venous hemorrhage from the uterus. I held the cervix between the hands. No other method was used to control the hemorrhage except a hypodermic of ergot, which was given before the uterus was incised.

The hemorrhage quickly stopped when the uterus was empty.

Before closing the abdomen the tubes were tied off, which I believe should be done in every case.

The child was given in charge of an assistant, and did not require any special care.

Both child and mother are now living and well.

The child weighed nine and one-half pounds.

The mother made a rapid convalescence, and says she did not suffer anything compared with previous labor.

The operation occupied fifty-five minutes.

So far as my limited experience justifies me in giving an opinion, I should recommend Cæsarean section when the life of the mother and child is in danger.

I hope the operation will be performed oftener, and that craniotomy and other rough instrumental work will be a thing of the past.

Discussion by Dr. L. A. Sanders, Concord.

The only case I remember of ever seeing of complete placenta prævia was of a young woman brought to the hospital from an adjoining town twenty miles away. History of frequent hemorrhage, two or three had seen her and tamponed her and kept her along until they felt she would best come to the hospital. She was up in a few days. I was an assistant on the other side of the hospital, and in that way saw her in

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consultation. She was not quite full term, about eight and one-half months. The question of Cæsarean section was mentioned, and it was finally decided to etherize the patient and deliver after a rapid dilatation, as she was at that time flowing quite freely, and had to be kept packed all the time. That case made an impression on me. Here was an apparently strong, healthy young woman in her first pregnancy, and begging of us to save her life. Rapid dilatation was done; she was delivered of a strong, healthy, living child; but that woman just simply bled to death on the table, died from loss of blood. Everything was done that could be done, but it will always seem to me that Cæsarean section in that case would have been better, and would have offered more hope to the mother, than to have tried rapid dilatation and delivery. I certainly believe that woman might have been alive to-day if Cæsarean section had been done.

Discussion closed by Dr. Brown.

In closing the discussion, it is only a proper courtesy to say that to a large extent I attribute the successful outcome of the case to the very careful preliminary asepsis of Dr. Milliken. Preliminary asepsis is an absolute prerequisite to this operation on account of the fact that they so readily become septic, and in the Vienna Lying-In Hospital no Cæsarean operations are performed unless it is assured that all previous examinations have been strictly aseptic.

With regard to the performance of Cæsarean section for placenta prævia the obstetricians usually oppose it because of the fact that a very large proportion of the children are not viable anyway and they usually deliver these cases by vaginal procedures or operations. However, I believe that this operation will receive much more right of way in these cases in the future than it has in the past.

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GENERAL CANCER OF THE PERITONEUM.

BY J. M. GILE, M. D., HANOVER.

It may be an open question whether this is a medical or a surgical disease, and so far as treatment is concerned whether it belongs to either. Texts, both on medicine and surgery, treat of the condition but briefly and when you have read one you have read all. This sentence, "Primary cancer of the peritoneum is exceedingly rare, it is generally secondary to disease of the stomach, liver, or pelvic organs," seems to be entirely conventional and sounds as if it were copied from one text to another. When a process has become so widespread as in most of these cases when they come to an exploratory operation or autopsy, it is difficult to say whether it did or did not originate in a given organ. In the five cases which I shall record the clinical symptoms at least were peritoneal from the outset, and with one possible exception the pathological finding indicated that the growth in the peritoneum was primary, although peritoneal covered organs were more or less deeply involved.

The first of these cases in which my attention was called to a widespread process of malignancy in the peritoneum was in a woman somewhat past sixty. Thirty years before she had had uræmia during pregnancy and since that event had never been in robust health. Her hands and feet were more or less misshapen either from gout or anthritis deformans. Otherwise she had been well and in spite of these conditions had been an active woman. Between three and four years before her death she began to suffer with occasional attacks of abdominal pain and periods of more or less severe constipa-

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tion. Nothing could be found objectively, however, until within about six months before her death, when scattered tumors of varying size began to be palpable in the different regions of the abdomen. This was followed by general ascites and the patient soon died in condition of asthenia with no one apparent cause predominant. Autopsy showed widespread and pretty even infiltration and thickening of the peritoneum, both parietal and visceral. Carcinomatous outgrowths of varying sizes appeared at different points on the peritoneum. Adhesions were present in many places making pockets that had filled with fluid, and these and the carcinomatous outgrowths formed the scattered tumors that had been felt.

The pelvis was pretty well filled with carcinomatous growth of the ovaries, and in this case the disease may have been primarily of the ovaries. This is the only case of the five in which any such predominance of the neoplasm existed in any tissue save the peritoneum, and even here there was very little clinical evidence of the presence of the disease until it had become widespread. The histological report was adenocarcinoma.

Case second: A woman of sixty-seven was admitted to Mary Hitchcock Memorial Hospital with diagnosis of ovarian cyst. This patient had been well all her life, save for the usual disease of childhood, until two or three months previous to admission. Then she began to lose her appetite. This was followed by nausea and after a time, to use her own expression, "the very thought of food became disgusting." Enlargement of the abdomen began to be noticed five or six weeks before admission to the hospital. On admission temperature was normal, pulse about 100. Quantity of urine only nine ounces in twenty-four hours, sp. gr. 1025 with a trace of albumen but no casts. The abdomen was a good deal distended and as the patient lay on her back rounded up well in front like a cyst or pregnancy instead of bulging at the flanks like an ascites. On change of position, however, the intestines floated readily to the top and the fluctuation

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wave was very distinct. The facial expression was moderately cachectic. Our diagnosis was finally in favor of ascites instead of cyst and we simply aspirated, after drawing off five quarts of clear fluid some irregular masses could be felt through the now relaxed wall. Examination of the fluid gave no information as to its origin and the patient was soon discharged from the hospital.

Sometime within the next three months (I do not know the exact date) I was invited by the attending physician to be present at an autopsy on this case. The peritoneal cavity was well distended with free fluid and there were but few adhesions. The peritoneum, however, particularly the parietal, was thick, dense and non-elastic, and studded more or less thickly with outgrowths of carcinomatous tissue. Some of the larger of these growths were the masses that had been felt after drawing off the fluid. The similarity to cyst in this case, particularly in the form of the abdomen, is readily accounted for by the condition of the peritoneum. It had become so dense and non-elastic that it held its contained fluid in a tight grasp instead of stretching out and allowing it to sag into the flanks. This characteristic appearance of the abdomen I have noticed in the three remaining cases and it seems to me strongly indicative of this condition of the peritoneum. I find no record of microscopic examination of this case, so conclude that I failed to take any tissue to the laboratory. The gross appearance, however, was so definite that I feel safe in classifying it histologically as carcinoma.

Case third was a woman of sixty-nine. She gave history of remarkably good health until one year before her admission to the hospital. At that time she fell down stairs, immediately after which she began to notice increasing enlargement of the abdomen. For eight months this was practically the only symptom. During the last four months there had been increasing pain, constipation and difficulty in urination. The pain and weight of the abdomen had during this four months confined the patient to her bed. For two weeks before admission there had been nausea and vomiting, but previous to

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that appetite and digestion had been good. On admission temperature was normal, pulse about 90. Urine, even under diuretic treatment, was less than twenty ounces in twenty-four hours, sp. gr. 1022, and free from albumen and casts. The abdomen was enormously large, of even tumorous outline, and on palpation gave distinct fluctuation. Exploration of abdomen by median incision revealed general ascites, about three gallons of dark straw-colored liquid being removed. The peritoneum was thick and dense and covered with profuse cauliflower-like growths both on its visceral and parietal layers. No other viscus appeared to be involved. Report of microscopic examination on a scrap of peritoneum that was removed was adeno-carcinoma. Following the operation the urine became much more scanty, the odor of the breath urinous and the patient fell into the dull semicomatous uræmic condition and died on the tenth day after exploration.

The fourth case was admitted to the hospital August 7, 1905, with history of diffuse enlargement of the abdomen that she first noticed after an attack of influenza the previons winter. The patient was sixty-eight years of age, and had previously always had the best of health. In the three months previous to admission there had been three attacks of diarrhœa, each lasting for two or three days. For several weeks there had been extreme anorexia and a good deal of œdema of the legs. Temperature normal, pulse about 80. The abdomen enormously distended and everywhere flat on percussion below the costal border. Generally fluctuant, but a solid mass felt in left side in the region of the spleen, and bimanual examination revealed a solid mass in the pelvis. Through median laparotomy about two gallons of straw-colored fluid was evacuated. In the left side in the region of the flank was a large mass of neoplastic growth apparently connected with the omentum, but adhesions about it were so extensive as to make it impossible to place it accurately. The pelvis was also filled with neoplasm and adhesions. The intestines were thickly studded with rather fine white or greyish masses. I carelessly failed to take any tissue from this case for examina-

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tion and I think it might fairly be argued that the appearance was not incompatible with tubercular peritonitis. The larger growths, however, were definitely like carcinoma, and despite the relatively acute course the case was entirely afebrile, which I believe absolutely rules out tuberculosis. This patient died two weeks after the exploratory operation in condition of general asthenia and extreme circulatory depression.

On case five I am not as yet in position to give full report, as the patient is still living. She is a woman forty-five years of age, with a history of previous good health except for an attack of typhoid some years ago. She has one child eleven years of age and another one year old.

Shortly after this last delivery there was an attack of rather severe pain in the region of the liver, diagnosed by her physician as billiary colic. It was of short duration, and in a few days recovery from it appeared complete. From this time she considered herself entirely well until four months ago, when she was attacked by pain in the right illiac region which, after a few days, became general over the abdomen. For a month the patient kept up and about her work, then the continuance of the pain and beginning enlargement of the abdomen compelled her to give up and go to bed. The bowels were constipated, urine scanty, appetite very poor and there were occasional attacks of vomiting.

I first saw her on admission to the hospital, February 5. The complexion was muddy, nutrition fair, but with the wrinkled skin that indicated that it was failing, heart and lungs negative, abdomen enormously distended. On palpation there was generally the springy feeling of fluid enclosed in a tensely drawn sac, except in the left hypochondrium there appeared to be a solid mass. Percussion was rather patchy, areas of dullness and tympany irregularly alternating, as if at some points adhesions prevented the intestines from moving normally in an otherwise free ascites. Urine seven to ten ounces in twenty-four hours, sp. gr. 1020, no albumen or casts. Blood examination showed 80 per cent. hæmoglobin, 5,600,000 reds and 7,800 whites. The different forms of whites

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were in practically normal proportion, except for a somewhat large per cent. of small mononeuclears, but this is fairly common in any chronic inflammatory process. The temperature during the time the patient was in the hospital ranged from 97 to 100. Pulse average a little above 100. The picture with slight variations was so close to the previous cases that I made the diagnosis of generalized peritoneal cancer; and previous experience made operation appear so fruitless, except that it hastens death, I advised the patient to go home. I have heard from her since as rapidly failing.

The study of these five cases has led me to conclusions somewhat different from those of the books. Instead of being secondary to carcinoma of stomach, liver or ovaries, I should say that it was ordinarily primary in the peritoneum, at least from a clinical standpoint, and that is the practical standpoint for the physician or surgeon. In none of these cases had the disease advanced in any other viscus to a point allowing of a diagnosis, or even to the production of a definite symptom, before the evidence of general peritonitis appeared. In only one case (the first recorded) did the operative or autopsy finding indicate that the disease was older or farther advanced than in the peritoneum. In no case was death caused by the progress of the disease in a single organ, but always by the general peritonitis and effusion. Though admitting that these facts do not prove that the disease had its origin in the peritoneum instead of in some peritoneal covered organ, they do show such a constant symptom group as to establish it as a definite clinical entity. And the symptomatology is entirely independent of the supposed primary seat of lesion. Generalized abdominal pain, coming on rather abruptly, distension with ascitic fluid appearing early, loss of appetite, nausea and vomiting following in order, cancerous cachexia, a generally afebrile course, exceedingly scanty urine, is practically, in brief, the history of every case.

The last mentioned symptom, scanty urine, is a characteristic and important condition, and after operation that lets out the abdominal fluid complete suppression seems to be the

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rule. The peritoneum appears to act as a drain through which all the fluids of the body flow out, leaving nothing for the ordinary channels of excretion. Osler says these cancers are probably endotheliomata instead of carcinoma. From the examinations I have made I should say the reverse, as in each case they have been carcinoma.

In conclusion I would submit that primary carcinoma of the peritoneum is reasonably frequent, that the clinical picture is so constant as to admit of a direct diagnosis in a majority of cases, that beyond simple aspiration surgical procedure is useless, and that even that may be followed by prompt urinary suppression.

Discussion by Dr. John H. Gleason, Manchester.

Mr. President and Fellows:

I think Dr. Gile is to be congratulated on the advanced position he has taken in regard to cancer of the peritoneum. His theory as to the primary focus of this disease is original and most interesting. It certainly presents to us a very important point for future observation and consideration.

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ENURESIS IN CHILDREN.

BY ROBERT H. MCCONNELL, M. D.,

ATTENDING PHYSICIAN FRENCH HOSPITAL, CLINICAL ASSISTANT DEPARTMENT DISEASES OF CHILDREN AT VANDERBILT CLINIC, COLLEGE OF PHYSICIANS AND SURGEONS, COLUMBIA UNIVERSITY, NEW YORK.

Probably there has been no more discouraging disease to treat than enuresis in children. Time and time again mothers will bring their little ones, and with tears in their eyes beg to have something done; for not only in the well-to-do is it a source of trial and embarrassment when a child is made offensive by the odor of stale urine, but in the poorer classes it is a great burden, for mothers must wash very often to keep the bedclothes clean, and the child's clothes soon become so offensive that they must be discarded, and this is an additional expense in a family perhaps which is already struggling for an existence; so I am going to lay more stress on the cause than on any other part of the subject. I am not going into the deep pathology of this disease, but will only take what we find every day, leaving the finer details to be found in the books.

A great many articles have been written on this subject, and the authors of all are apparently separated in their views. I have investigated a great many of these reports, and will give you some of them.

There are two varieties of enuresis—one, the true enuresis, where the urine is discharged from the bladder without the knowledge of the patient; and the other, the *false* condition, where there is an increased desire, occurring so suddenly

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that the urine is discharged before the person can prepare to attend to it in the usual way.

"If a child cannot control, or does not know that the urine is passed during its third year, enuresis may be said to exist." (Holt.)

As to the causes of enuresis, there are many.

Bierhoff, in an article on the subject in *The Feshschrift*, in honor of Dr. Jacobi, in 1900, gives the following causes, which he has collected from various works on the subject:

CENTRAL NERVOUS SYSTEM.

Hysteria, neurasthenia, epilepsy, tabes, myelitis, cretinism, idiocy, dreams.

GENITAL TRACT.

Phimosis, redundant prepuce, preputial adhesions, epispadias, hypospadias, urethritis, vulvo-vaginitis, cystitis, vesical calculus, tumor, tuberculosis, renal calculus, pyelitis, nephritis, urethral obstruction, fragments of calculus impacted in vesical sphincter.

OTHER CAUSES.

Acute febrile diseases, indigestion, constipation, diabetes, spinal caries, rhachitis, onanism, hypertrophied tonsils, adenoids, eczema, intestinal parasites.

Bierhoff also gives some of the following references:

Guyon says the etiology is not clear, sex causes no predisposition, heredity is unmistakable.

Desault believes that in irritability of the bladder the sensation caused by contraction of the bladder and the discharge of urine is so slight that the entire act occurs uninfluenced by the will and without disturbing sleep. In the course of time, as the child grows, he or she pays more attention to the act, that the irritability diminishes and the case is finally cured.

Trousseau believes it to be nervous, and therefore uses antispasmodics.

Baginsky believed it a neurosis.

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Holt says the condition may be due to the central nervous system, the urine, the bladder or any adjacent organ.

While I have given a list of causes, I have come to the conclusion, after several years' study of this trouble, that the cause in most of the cases of enuresis is *not* to be found in some very abnormal condition, but is most frequently found in the habits, the surroundings or the temperament of the child; and just as soon as these are corrected the enuresis stops. The stone in the bladder, the tumor and other big causes are the rare occurrence.

If we are to be successful we must enquire into every habit the child has.

Any condition which will cause a congestion of the mucus membrane, such as phimosis, redundant or adherent prepuce or masturbation, are great causative factors.

Perhaps a great cause is the hypertrophied tonsil or adenoid, for the deep sleep or semi-asphyxiation which these children have, takes away that desire to urinate, and the urine comes involuntarily.

This is the reason why cases are sometimes cured by removing adenoids and tonsils.

Instead of taking each disease in turn, I shall mention what I have found most commonly at the Vanderbilt Clinic, College of Physicians and Surgeons, to be the cause of this miserable condition:

Indigestion and constipation, causing the patient to drink large quantities of water before retiring; tea, coffee, acid urine, adherent prepuce, tonsils and adenoids, lack of proper ventilation in room, night drawers, masturbation, worms. These are the commonest causes, but it is sometimes as hard to find these as it is to find the big cause.

The history we get is often as follows:

Mother brings child, say a girl of eight years, because she wets the bed. She has tried all manner of cures, at first whipping the child—a very bad thing to do, by the way—but without result. Then a doctor is consulted, some medicine given, without result. He is consulted again, and again;

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other doctors are consulted, with the same result, until the mother is discouraged, and she stops to wait until the child grows out of it.

Or a history as follows:

Boy, say of six years, well until a few years ago, when he had some acute illness, like measles or scarlet fever. Boy wets his clothes, and also bed. He can tell when he wants to pass his urine, but is unable to hold it long enough to attend to in the normal manner. Treatments of all kinds are of no avail.

I could go on indefinitely. You all know the story. We have all had our experiences; and when we would cure a case, we thought we had discovered a cure for enuresis.

Now, what shall we do for these cases? A friend of mine advises calling in the plumber.

I believe each case is a study in itself, and if we are to succeed, we must start at the time the child arises and follow its course through the whole day. This has been my scheme for several years, and with exceedingly good results. Sometimes it would take a little time to find the real cause or causes; but when we did, the case apparently cured like magic. My plan has been as follows:

Time of waking, hour for breakfast, food for breakfast, habits between breakfast and noon, hour for lunch or dinner, food for lunch or dinner, habits between noon and supper, food for supper, habits between supper and bedtime, hour for bed, sleep restless or quiet, snoring, condition of ventilation, bed clothing, appetite, digestion, bowels, tongue.

Then the character of the enuresis:

Whether large amount of urine or a small amount at a time, whether a simply irritated bladder or a true enuresis.

Then comes the examination of the patient:

Lung, heart, abdomen, and especially the condition of the genito-urinary organs, a vaginitis or a urethritis.

Great thoroughness is of vast importance in this examination—condition of child's nervous system, family history.

After we have this all down on paper, we make our deduc-

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tions, and we can usually make our diagnosis. We may find nothing in the history, but there will be something in the child's physical condition or *vice versa*.

Treatment is simple after the diagnosis is made. It may be simply a correction of a habit, or a tonic or antispasmodic. My plan is to correct all bad habits, put the child on proper feeding and proper hours; bed at seven o'clock, cut out all fluids after four o'clock; if due to polyuria, limit the amount all day; if due to acid urine, give large quantities before four o'clock; avoid excitement; if child is very nervous or has chorea, I take them from school; adenoids and tonsils are removed, and preputial adhesion or a vaginitis attended to.

As for drugs, they are discouraging. Everyone uses belladona. I have been disappointed in belladona. Sometimes it has done good when combined with ergot and bromides. I am rather in favor of arsenic combined with iron.

I believe patience and perseverance will accomplish a great deal in these cases, and those who expect rapid cures will be disappointed.

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LACERATIONS OF THE PERINEUM AND THEIR TREATMENT.

BY W. J. BEATTIE, M. D., LITTLETON.

Though this expression has long been in use it is liable to be misinterpreted. The perineal body should not be studied as a separate entity, it is merely the anterior portion of the sacral segment of the pelvic floor and is a composite structure composed of different facial and muscular structures, of which the most important are the following: Triangular ligament, anterior and posterior layers, recto-vaginal visceral layer, anal fascia, and deep superficial fascia.

The muscles that meet in the perineum are the transversus perinei, transversus perinei profundus, small offshoots of the levatores ani, sphincter vaginal and sphincter ani.

The significance of the laceration depends upon the extent and number of these various structures divided.

The diagnosis of laceration of the perineum is made by a careful inspection of the genital organs after delivery.

The extent of the lesion is estimated by including the recto-vaginal septum between the thumb and index finger.

In my own private practice in recent years I have done the immediate operation with good results and I wish to emphasize the great importance of this operation. It diminishes the risk of infection and shortens the puerperal period. It is true that the object aimed at may not be attained in private practice; however, failure, I think, is the exception. The argument that the operation is in itself a confession, does not deserve discussion. For the performance of this operation the patient should lie upon her back with the hips well over

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the edge of the bed. The knees should be held in position with an apparatus designed for that purpose. The wound should be prepared by carefully washing away blood and clots with warm lysol solution, and by removing shreddy portions with scissors. If the tear be superficial, or of medium depth, a series of interrupted stitches should be introduced along the wound. Each should enter the skin about one-eighth inch external to the tear and should be carried deeply under the raw surface, emerging at a point in the skin opposite the place of entrance.

When the laceration extends along the vagina or vulva, it should be closed. Thoroughness is necessary in performing this operation in order that the wound may be closed in the entire depth and not the skin edges only.

The suture material may be linen, silkworm gut, silk, or chromic gut. Antiseptic dressings may be kept on the vulva several days after the operation.

Catheterization may be necessary for a day or two. The bowels should be kept regularly open, straining at stool being forbidden.

Complete lacerations of the perineum involving the sphincter-ani muscle differs in some details from the operation just described—first, in the passage of the sutures; second, in after treatment.

The sutures should be of silkworm gut. The first two of these should be introduced to the left of the anus, should pass somewhat deeply under the left pit, should sweep around under the border of the torn septum, and pass under the opposite pit, emerging to the right of the anus. This draws the wound into a small compass and leaves no part of the suture in the bowel to absorb and carry septic secretion. This is called the purse-string suture, and was devised by Dr. E. C. Dudley, of Chicago.

After the operation moist anti-septic dressings are constantly applied to the perineum and vulva for a few days. The vagina is douched every other day with antiseptic solution—a normal saline solution containing formaline, gtt. 24 to a pint.

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The patient should be catheterized every four to six hours, for the first few days. The bowels should not be disturbed for six or eight days. At the end of that time a full cathartic of castor oil or compound licorice powder should be given.

During the first week whenever the bowels are about to move, it is well to give a rectal enema of eight ounces of olive oil. In giving the enema the syringe-tip should be passed carefully along the posterior wall of the anus away from the anal sutures.

If there is no suppuration, the sutures should not be removed until the fourteenth day. In other respects the after-treatment is the same as for incomplete lacerations.

Discussion opened by E. O. Crossman, M. D., Lisbon.

Mr. President and Fellows of the Society:

It seems to me that this is one of the extremely practical conditions that comes to the attention of every medical man. A lacerated perineum, it seems to me, every man ought to be able to take care of and take care of well. Every practitioner should know all there is to be known concerning lacerations of the perineum. It often happens, I think, that men do not follow their cases, that the obstetrician does not make a thorough examination of the parts. It is wise to form good habits and still I think we may form habits that are peculiar to ourselves and we may become more or less negligent in the care of these cases. It seems to me that a habit of examining a little more cautiously and doing a little more to these cases to-day than we did yesterday is the proper frame of mind to get into. If at the first examination of the perineum there appears to be no laceration we should not let the patient rest, nor should we conclude that if we do not discover anything the patient is all right, because sometimes this examination is done under unfavorable circumstances. Sometimes an examination is not made because we are anxious to avoid exposing the patient, and sometimes the child demands all our attention. No matter how difficult it may be to make a thorough examination

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at that time, it should be done. Also in the course of a month or two a second examination should be made, as often there may be a deep laceration that is not discovered on the first examination, and therefore it is very important that a thorough second examination be made. Of course the floor of the pelvis or perineum tends to support the urethra, vagina and bladder, but it does not support the uterus; and to repair an old perineum is of no advantage in restoring a misplaced uterus to its normal position. Yet we do find local troubles that are important as a result of lacerations. Among these conditions we very often find rectoceles which are pretty sure to interfere with the normal action of the bowels. Next we find cystoceles which are very dangerous, as we get accumulations of urine and there have been cases of stone in the bladder reported as result of neglect along this line.

As a result of neglected laceration of the perineum I am sure I have seen a number of cases of neurasthenia. So, I say that, while this condition is familiar to every practitioner, it is wise to review the literature often and give much thought to laceration of the perineum. If we do this we will find it much to our advantage and the advantage of our patients. I think the doctor has given us a very practical paper.

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UNUSUAL COMPLICATIONS OF TYPHOID FEVER, WITH REPORT OF CASES.

BY R. G. BLANCHARD, M. D., DOVER.

Typhoid fever, when it runs its usual uninterrupted course, and a good nurse is in attendance, does not give the physician that mental worry which some other diseases are apt to do; but when we get the unusual and severe complications, it then becomes an entirely different matter and is likely to keep the physician's mind fully occupied, and the anxiety and worry is apt to increase the number of gray hairs already allotted to him.

Many of the severe complications of typhoid fever come suddenly and without warning, and require immediate attention.

It is in such cases that the presence of a well-trained nurse, who has also had experience, is invaluable.

Take for instance hemorrhage from the bowels: the proficient nurse has, almost before the messenger or the telephone has reached the physician, carried out the usual line of treatment indicated in such cases, and this prompt action has, I believe, saved the life of many a patient.

It is to the advantage and comfort of mind of the physician, and the welfare of the patient, that each case should have the best nursing possible.

I wish to speak of three cases, in which I think you will agree that the complications were unusual.

FIRST—Arthritis, probably rheumatic.

SECOND—Pneumonia.

THIRD—The combination of hemorrhage from the bowels, tetanus and perforation of the intestine.

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Case 1. *Arthritis.*

The patient, a young lady about twenty, came home from a neighboring city sick with typhoid fever.

With the exception of a high temperature, the initial run of the fever was uneventful, temperature becoming normal about the end of the fourth week.

After two or three days of normal temperature, without change in diet or anything that might be an exciting cause, the fever suddenly lighted up and we started in on a relapse.

At the end of the second week of the relapse, arthritis suddenly developed; first in the ankles, then the knees, wrists, shoulders and several more joints.

These joints were affected one after another similar to an attack of rheumatic fever.

There was pain, redness, swelling and restricted movement; we also had general sweating; fever kept up to between 102 and 103 during most of the attack. I gave quite large doses of salicin and had the joints wrapped in cotton.

At the end of about the tenth day of the arthritis, the temperature became normal, the typhoid and the arthritic symptoms had passed away, and the patient entered upon an uninterrupted convalescence.

In looking over medical literature upon this subject, I find but very little mention of arthritis complicating typhoid fever, and thinking that it might be of interest to the medical gentlemen present, I have given a very brief account of this case.

Case 2. *Pneumonia.*

Pneumonia is rather a rare complication of typhoid fever.

During a series of fifteen hundred hospital cases, it was observed fifty-two times.

Tyson says that "the term typhoid pneumonia is one in common use by many who have no definite notion of its meaning, and like the term typho-malarial has occasioned confusion.

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In the first place the case may begin as a lobar pneumonia, the intestinal symptoms appearing at the end of the first week or later, at which time also the spots may appear, establishing the diagnosis, while the usual crisis of pneumonia fails to make its appearance.

Again, a pneumonia may supervene in the second or third week of a typhoid fever as a complication, in which the true relation is less difficult to determine.

Finally there may be a true pneumonia, to which stupor, a dry tongue and general adynamia may be added, without the distinctive lesions of typhoid fever.

This is true typhoid pneumonia, which it may not always be easy to separate from the typhoid fever beginning with pneumonia.

Both of the forms of pneumonia may be caused by the typhoid bacillus or the pneumococcus.

This case of pneumonia following and complicating typhoid fever, occurred in a young man about twenty-one years of age.

His life being much out of doors, he was of strong physique and had the best of habits.

He had always been well, seldom having anything in the way of illness, except the mildest of troubles, an occasional cold.

His attack of typhoid which was quite severe, the temperature being high, with considerable delirium, ran about four weeks, at which time the temperature was getting well down and the patient feeling much improved.

I saw him the night before the initial chill ushering in the pneumonia, and he was feeling so well and all the symptoms were so improved, that we were expecting convalescence to rapidly take place.

In the morning I found that at about midnight the patient had a severe chill, lasting some time, followed by a temperature of 106.4, it being 105.5 at my visit; pulse 150 and rapid respiration.

The usual symptoms of a typical case of pneumonia on the

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right side followed. We had a high temperature, rapid pulse and respiration right through the attack, which terminated fatally on about the tenth day. This was the first case of pneumonia complicating typhoid fever that had ever come under my observation, and Dr. Morgan, who saw the case in consultation and concurred as to diagnosis, stated that it was the first case he had seen.

CASE 3. *Hemorrhage, Parotitis and Perforation.*

August 29, 1903, I was called to see Mr. O——, aged thirty-eight, who had that day returned home from the middle part of the state, where he had been at work for a short time.

Mr. O—— had not been in his usual good health for some time. He had been over-working, often staying up until one or two in the morning, and then arising at six to begin his day's work.

For several months his sleep had been much curtailed and meals very irregular.

I found him with intense headache and backache, high fever, and feeling generally very sick, and he stated that he had been in this condition three or four days.

After a day or two the case was diagnosed typhoid fever, and it run an interrupted course of three weeks from August 29.

At the end of twenty-one days the temperature became normal and was at that point for two days, when, without warning, it shot up and we were in for the second edition.

Patient took nourishment very well, but lost strength rapidly.

During a considerable part of the relapse it was necessary to catheterize two or three times daily.

October 3, patient had quite a severe hemorrhage from the bowels, but by prompt treatment from the nurses present, soon rallied from the depression caused by it.

October 6, a second hemorrhage occurred, and all day patient was in a very weak condition, and wavered between life and death.

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Next morning he had rallied considerable and seemed much brighter.

At my evening visit the nurse called my attention to a swelling beneath each ear, which had developed during the day. She also said that since the first of the afternoon, he had not been able to open his mouth to take even water.

I found patient unable to separate his jaws, neither could I with any moderate amount of force open them in the least.

The parotid gland on each side was very much swollen, and very sensitive to the touch, also quite painful.

Hot fomentations were applied, but the swelling of glands could not be reduced, neither was he at any time relieved of the trismus.

Water, milk and beef juice were put into his mouth between cheek and teeth, and allowed to run between teeth and so swallowed.

Of course with almost constant attention, he could be given but very little nourishment.

During the forenoon of October 11, patient was suddenly taken with acute and severe pain in the right side of abdomen, followed by symptoms of collapse, denoting that perforation had taken place; peritonitis followed and patient died during the evening of October 12.

During the run of this case I had at different times the counsel of Drs. M. C. Lathrop and A. N. Smith; Dr. Lathrop being in joint attendance the last few days.

Parotitis is a very uncommon complication of typhoid fever. In a series of two thousand cases it was present in but forty-five.

Osler says that it is a very fatal complication, but that in his series of cases there were four or five recoveries.

Trousseau looks upon these swellings as a very grave accident, and says that he has scarcely ever seen a case recover in which it has occurred.

It undoubtedly may arise from extension of inflammation along Steno's duct; also from metastatic inflammation.

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Perforation has been noted at autopsy in 5.7 per cent. of cases.

Liebermeister found perforation in 1.3 per cent. of over 2,000 cases.

"In 4,680 cases collected by R. H. Fitz, the mortality from perforation was 6.58 per cent., which may be said also to represent nearly the frequency, since heretofore nearly all have died."

"As to the location of perforation, Hawkins found it in 61 of 72 cases in the ileum, 3 in the cæcum, 3 in the appendix and 5 in the colon, most of the latter being in the sigmoid flexure."

In 167 cases collected by Fitz, the ileum was perforated in 136, the large intestine in 20, the appendix in five, Meckel's diverticulum in four, the jejunum in two.

The number of perforations is usually one, but as many as five have been found.

The International Text-book of Surgery of recent date says that nearly 100 cases of perforation have been subjected to operation, with a mortality of over 80 per cent., and that most of the successful cases were in hospital practice.

"The dangers of operation are very great, mainly on account of the low vitality of the patient; but also because to the dangers of peritonitis and shock, are added those of the sepsis and exhaustion of the original disease."

Discussion by Dr. A. Noel Smith, of Dover.

Mr. President and Fellows:

I have come to the conclusion to-day, in thinking the matter over, that I am placed in a very unfortunate position. I am a member of the House of Delegates, and am also on the programme to discuss this paper. I have spent the greater part of the last hour peeping through the window up stairs, keeping tally on the proceedings so I would know when the time would arrive for me to inflict myself upon this august body.

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I have been much interested in the paper presented by Dr. Blanchard, of Dover, and he has certainly very instructively reported his typhoid fever cases which were so beset with complications.

Typhoid fever itself is surely of special interest to every physician, occurring as it does in all parts of the world. No climate and no locality is exempt from it.

Much is spoken and written of this disease every year, and each year we are adding to our certain knowledge concerning it. Something may be judged of the prominent position accorded to typhoid fever in the medical world from the fact that one hundred and fifty-nine pages of brevier type are filled by Corfield in his "Milroy Lectures" upon the "Etiology of Typhoid Fever and its Prevention."

Now it is bad enough to be obliged to endure enteric fever in one's own person in its simplest and mildest form, as those of us who have been afflicted with the disease can testify; but when severe complications arise, especially those to which the writer of the paper under discussion has alluded, the suffering and danger are greatly multiplied.

Time will not permit me to refer to all of the complications cited. I will mention one—lobar pneumonia—which has seemed to be in the past an uncommon complication of typhoid fever. However, it has been suggested that the symptoms of pneumonia are sometimes so light, or so obscured, that the condition is probably often overlooked. I am inclined to the opinion that, as lobar pneumonia, uncomplicated and uncomplicating, is more prevalent now than formerly, we therefore have it complicating typhoid fever more often. Some very recent writers seem to favor this view. Dr. James Magoffin French regards lobar pneumonia as quite a frequent complication. "It sometimes develops," he says, "before the typhoid infection has manifested itself, and may have nearly run its course before the latter disease is recognized. The crisis is usually prevented by the typhoid infection. Whether the pneumonia is induced by the typhoid bacillus, or is due to a specific organism, has not been determined."

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I desire to emphasize what I said in the beginning, that I was deeply interested in this paper. All medical subjects possess an interest for us as medical men; but these common enemies, like typhoid fever, against which we battle every day, hold a vastly more important place in our professional hearts.

The more such practical and progressive topics are presented, instead of the problematical and axiomatical, the less cause will the non-attendant upon medical meetings have to complain, as I noted one did a short time since, that he was "awfully tired of listening to the annunciation of the novel facts that Epsom salts will move the bowels, that quinine will cure malaria, that mercury is useful in syphilis, that silver nitrate will cure—or will not cure—gonorrhœa, and that pneumonia is a self-limited disease."

Discussion by Dr. I. G. Anthoine.

Mr. President and Fellows:

I have had a good many cases of typhoid fever, and with that disease in particular I have learned not to give up the case as long as the patient could breathe. Some way they seem to hang to life longer with typhoid fever than with any other disease. I have seen them when the only symptom of life was that the patient could breathe, so deaf they could not be made to hear, and entirely unconscious; I have seen them get well under those circumstances. I have learned never to give up typhoid cases as long as they can breathe. I had not given this any thought, and do not think I will attempt to discuss the paper.

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CEREBRO-SPINAL MENINGITIS.

BY F. VON TOBEL, M. D., LEBANON.

The term cerebro-spinal meningitis, or to be more exact, epidemic cerebro-spinal meningitis, is used to define an acute infectious disease characterized by an inflammation of the pia mater of the brain and spinal cord. It is, therefore, not to to be classed as a spinal disease *per se*, but rather an infection, having for its field of action the covering of the spine and brain.

The disease is known by many names on account of the great variety of forms it assumes, and the particular symptom which appeals to an individual observer. Cerebro-spinal meningitis, spinal fever, cerebro-spinal typhus and spotted fever are a few of the many names given to it. The name spotted fever is, I believe, wholly of American origin, and, of them all, is the least appropriate and most misleading, as it gives no inkling of the real trouble and refers only to one symptom, which symptom itself is absent in a very large number of cases.

History.—Undoubtedly the disease is of ancient origin, but only became recognized as a distinct entity about one hundred years ago. Previous to that it was probably considered some form of an already existing disease like typhus fever.

From 1805 to 1816 it visited many and widely separated parts of the world. The first to be described with any precision as a disease by itself was in Geneva, beginning in 1805, in which there were thirty-three fatal cases. The following year, 1806, it broke out in Medfield, Mass. Then for two years it raged quite extensively in Massachusetts, Connecticut,

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Ohio and Kentucky. In 1806–07 an epidemic occurred in the Prussian army; in 1807, among Spanish prisoners; in 1811, in Dantzic; in 1813, at Mayence and Brest; in 1814, in Grenoble and Paris. That was the end of the widespread epidemics for the time, though from then until 1837 limited epidemics or sporadic cases occurred, attracting little attention.

From 1837 to 1849 it was quite prevalent in France and Italy, being confined largely in those countries to the troops and garrison cities, and supposedly being conveyed from place to place by the moving of the troops. During this period epidemics are reported from Denmark, Ireland and the United States. From 1854–61 the whole of Sweden was affected by it. The disease traversed the country systematically from south to north, commencing each January where it left off the preceding May or June. In the seven years there were about eleven thousand cases with four thousand deaths in that country. During that time the neighboring country, Denmark, was only slightly invaded.

From 1861–68 was another epidemic period, being widespread in Germany, Ireland and the United States. From 1868 till nearly the present time the world was free from extensive outbreaks, sporadic cases or limited epidemics, however, occurring in many places from time to time. Nearly every country has been visited by it, Smyrna, Jerusalem and Oceanica having been invaded. So we see it is not confined to any geographic area.

Etiology.—The season seems to have a marked influence on the disease, a very large per cent. of cases occurring the first five months in the year—that is, the latter part of the winter and early spring. During the first six months of 1905 there were in Manchester 89 deaths from the disease, distributed as follows: January, 2; February, 11; March, 27; April, 27; May, 10; and June, 6. I endeavored to obtain statistics from other states, but was unable to do so as they had not been compiled. But a study of all the known epidemics will give just about the same distribution, showing the disease is pre-eminently one of the first half of the year.

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Defective hygiene and overcrowding undoubtedly has an influence on the propogation of the malady, though I think largely in a general way by lowering the resisting powers of the people so surrounded rather than in any specific way.

Age is a predisposing factor. Children are most susceptible, youth next, the percentage of cases growing rapidly less as age advances. Of about one thousand one hundred cases occurring in Massachusetts from 1887 to 1895, six hundred and seventy-six cases, or about 60 per cent., were in children under five years of age; two hundred and seventy-five, or a little more than 20 per cent., were between five and ten, leaving only 20 per cent. for all ages above ten.

It attacks people robust and of previously good health by preference. Of one hundred and twenty-four cases studied by one observer in Cologne from 1885 to 1892, not one was a tubercular or scrofulous person. Others have not found this apparent immunity of the tuberculous so marked, though it does appear to be true that the most vigorous are the most susceptible to the disease.

The disease, especially when appearing as an epidemic, frequently, and I think usually, exists alongside of some other epidemic disease like influenza or typhus fever, with the latter of which it was formerly, and to some extent is now, confounded. It surely is present most extensively during the season when we look for the influenza to rage.

Whether the disease is contagious or not is a question on which authorities differ. I think the foreign writers are more inclined to believe it distinctly contagious than do those of our own country. While they think it less contagious than scarlet fever, measles, etc., they hold, nevertheless, that it is contagious from the patient direct or through a third person not affected, or from clothing or any article which has been in contact with a person affected. It does n't seem that a study of the 1905 epidemic warrants such an assertion. Cases have been treated right in public hospital wards without a single instance of known contagion. When there had been about fifty cases in Manchester, a man who knew told me

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there had been but two instances where there had been more than one case in a family. Whether that held true throughout the epidemic I cannot say. Most of the victims were in thickly-crowded tenement houses, with everything by way of filth and unwholesome surroundings to favor a spreading if the disease is contagious in any appreciable degree. The germ is of very low vitality, being quickly killed by drying or exposure to sunlight, which makes it highly improbable that it is conveyed by dust. There is no question but what the disease would be contagious if the germ could find passage from one affected to the meninges of another person. What is doubted is the ability of the contagium to thus be transferred.

The active cause of the disease is the diplococcus intracellularis meningitidis. How it enters the body is not definitely known. It is probably present at all times, like pneumonia or influenza; at certain seasons or under certain conditions becoming more numerous and virulent, thus producing an epidemic. The germ probably is inhaled, and finds its way into the cerebro-spinal cord through the lymphatics, possibly through the cribriform plate of the ethmoid. The germ evidently at times produces a coryza when no meningeal symptoms arise, because the germs have gone no farther than the nasal mucous membrane, where it is frequently found in a healthy person.

Pathology.—The pathological process takes place in the pia arachnoid of the cerebro-spinal canal. It is characterized at first by a serous, later a purulent effusion on the visceral side of the pia mater, and if patient lives more than a few days it often appears as a fibrous, leathery membrane super-imposed upon the brain and cord.

In the cerebro-spinal fluid obtained by lumbar puncture, the diplococcus is almost invariably present in the early stages of the disease. In cases that run ten to twelve days it is less often found, and in such as run weeks or months it is rarely found even in cases where it was present early in the disease, showing that the active life of the germ is short. The germ

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is also found in the contents of the herpetic vesicles situated on different parts of the body.

Diagnosis.—The diagnosis is often obscure, especially in sporadic cases. It can easily be confounded in the early stages with influenza, typhoid or typhus fever, or with most any of the acute infectious diseases. The disease is often ushered in abruptly with a chill and headache, not unlike the diseases above mentioned. Temperature and pulse are somewhat variable. In young children the temperature is usually very high. In older people it may be high, but more often moderate, or occasionally subnormal. Pulse does not follow the temperature as in most diseases, but may be as low as 40, or in a few hours, or minutes even, be 150 with but little, if any, change in the temperature. The headache is as apt as any way to be frontal, especially at first. In some cases we see a retraction of the head, in others not; probably in the greater part of the cases retraction is present sometime during the course of the disease.

Spots sometimes show in from one to three days, hence the name spotted fever, though I think that symptom is by no means constant enough to figure in the name. However, in some epidemics it is said to be very common, while in others it is entirely wanting. Herpes of the lips and nose occur as frequently or more so than the petechial spots generally ascribed to the disease. Hemiplegia and unequal pupils are seen in a certain per cent. of cases, though it is not a constant symptom. In the majority of cases an active delirium is present; in others the patient passes rapidly into a state of coma and death ensues.

The most valuable aid to diagnosis is lumbar puncture and examining the fluid obtained for the diplococcus. In that way only can we say positively that a given case is epidemic cerebro-spinal meningitis as distinguished from tuberculous meningitis or that resulting from the pneumococcus, although propably 90 per cent. of cases of primary meningitis are due to the diplococcus, the pneumonic and tuberculous forms more often being secondary to the respective processes elsewhere.

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Prognosis.—The prognosis is always grave, the mortality varying in different epidemics from 30 per cent. to 75 per cent. The mortality is usually greater during the early part of an epidemic.

Course.—The course of the disease varies from a few hours to some months, though in the subacute cases probably the trouble is not always, or perhaps never, due to the continued activity of the germ, but to the resulting interference with the nerve centers, and a slow death through an inability of the system to overcome the damage done, or from a general neuritis; or, if a partial recovery takes place, it is often with the loss of some function like hearing or seeing, or with perhaps a more or less extensive paralysis.

Treatment.—The treatment has been largely symptomatic —emptying the bowels thoroughly with a mercurial or saline, controlling pain and delirium with sedatives, as bromide, chloral or opiates, preferably hypodermically, together with ice to head and spine, or counterirritants to spine, warm baths and attention to the diet, has been about as successful as any line of treatment. More than thirty years ago Professor Ziemssen in his classical encyclopedia said, and he put it in italics: "Morphine may be regarded as one of the most indispensable remedies in the treatment of epidemic meningitis," and from a medical standpoint we can say no more.

During the recent widespread and fatal epidemic physicians have been roused as never before to find some method by which the disease might be successfully combated. As yet but little of value has come to light. Lumbar puncture seems to give at least temporary relief in some cases, and doubtless has saved some by limiting the pressure on the brain and cord until the germ had ceased to be active. In a recent article in a foreign journal a Dr. Lenhartz details his experience with lumbar puncture as a curative measure. He has had good result. Cases where he has used it early often are convalescent by the eighth day, and in one very unfavorable case the puncture was not begun until the fortieth day. Improvement commenced at once, and the patient made a per-

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fect recovery after a tedious convalescence. He advises the institution of this measure at the earliest possible moment that the diagnosis is made, and a small amount of fluid withdrawn every day or every second day.

One doctor at least, Dr. Helmuth, has trephined the skull and drained. The operation was pronounced a success, but I imagine the patient died as I never heard anything more about the case.

Of late diphtheria antitoxin has been quite extensively used, and with sufficient results, I think, to warrant its further trial. At the present I should say lumbar puncture and the diphtheria antitoxin, together with symptomatic treatment, offers as much hope as anything, which is saying but little.

During the epidemic of 1905 Lebanon was visited by the disease, we having six cases with five fatalities during the winter and spring. None of these were my cases, though I saw all but one of them in consultation. A brief mention of these cases will be all that could be interesting.

Case 1 was a strong, unusually rugged appearing man about forty-five years of age, a painter by trade. He was taken sick January 29. The physician very naturally took it to be a severe case of grip. He had a severe frontal headache and other symptoms of the grip. He kept steadily growing worse. I saw him on the morning of January 30. Temperature had been running around 103, pulse somewhat lower than would naturally correspond with the temperature. He had become violently delirious during the night. At that time he showed unequal pupils and partial paralysis of left side. He failed rapidly, and died January 31, after being sick forty-eight hours.

Cases 2 and 3, brother and sister, aged five and nine respectively, were taken sick about the same time, or it may be a day or two apart. Both taken with convulsions. They continued to have some convulsions for three or four days at frequent intervals, between the attacks they lying in a state of semi-coma. In a few days the symptoms began to clear up somewhat, and they passed into a state like a slow fever. The

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temperature averaged about 101 or less. I saw them after they had been sick five or six weeks. Found them emaciated. Inclined to lie curled up in bed, and the least attempt to turn them or to straighten their limbs or raise their heads would call forth cries of pain. After another month they appeared to improve slowly, so they were up and about, though with some loss of muscle power and control. Suddenly, about three months after the commencement of the attack, the older one developed acute cerebral symptoms and died in less than forty-eight hours. The other child, I believe, is well.

Case 4, strong young man twenty years of age, working in key-shop. First called doctor on morning of March 21. Was thought to be suffering from grip or beginning typhoid. Most prominent symptom was frontal headache. Temperature high, pulse rather slow in comparison. I saw him in consultation that night. Found him in a comatose condition, and it was evident he was dying from meningitis, which he did early the following morning, twenty-four hours after the onset of the disease. In this case there was no active delirium, no spots and no retraction of head.

Case 5, girl nine years of age. Had had a cold, the mother said, for a few days. Doctor was called March 22. I saw the child about two hours after. Girl had been very restless and delirious, but at that time was verging on coma with some rigidity of muscles, especially of neck. That was about the time that diphtheria antitoxin was first being talked about for this disease, and we decided to use it; so four thousand units were injected. Four hours afterward the attending physician found a marked improvement. The mind had cleared up, and the child appeared in every way to be very much better. The antitoxin was used four times, twelve thousand units being given in all, I think, each injection being followed by an amelioration of the symptoms. But in spite of all she would have relapses or exacerbations of the trouble, until finally she died, thirty days from the beginning of the attack. The antitoxin was not used in such heroic doses as is recommended by those who have the greatest faith in it, nor was

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lumbar puncture done, which is also advised in conjunction with the antitoxin, and which is probably a more important factor than the latter in arresting the disease.

Case 6 I did not see. Boy about seventeen, strong and healthy. Worked in key-shop. Was taken sick about April 17. Symptoms severe from start, some headache and active delirium. Marked herpetic eruption, but no petechia. Antitoxin was used, but the boy died in four days.

Two of these cases worked in the key-shop, as did also the father of one of the children. It spread great consternation among some of the employees, but I doubt if there was any connection between the shop and the cases.

In conclusion, I will say that I do not take a pessimistic view of the situation, but have faith that, given the opportunity, the medical profession will in this case, as it has in many others, rise to the occasion and point a way out of the darkness, that we may not stand back humiliated and helpless before the dread disease. And the fact that the disease is still unconquered should be an impetus to each for still more untiring work and searching investigation.

Discussion by John H. Gleason, M. D., Manchester.

Mr. President and Gentlemen:

First, in regard to the etiology of cerebro-spinal meningitis. During the winters of 1903–4 and 1904–5 there were a considerable number of cases reported in Manchester. It was noted that the disease usually selected certain quarters of the city, namely the tenement districts. It was also seen that the cases were found in crowded and poorly ventilated houses, and in rooms where little if any sun was to be obtained. That this matter of poor surroundings is of importance etiologically, I think is a matter that should be dwelt upon in discussing the disease.

Second, as to treatment by medication, antitoxin, etc. About one year ago, at a meeting held at the Academy of Medicine, New York, a series of papers were presented on

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this subject. Dr. Francis Huber, physician to the Bellevue and to the Roosevelt Hospitals, reported very exhaustively on the treatment of meningitis. After thorough trial of all methods, he was forced to conclude that there was little to be accomplished outside of symptomatic treatment. Further, that nearly all affected with true cerebro-spinal meningitis die, diagnosis being verified by lumbar puncture. Those few that recover belong to the so called chronic or subacute type of the disease, and recover with or without complications after the disease has run a long course.

There was present also at this meeting a physician from a city in Connecticut, a board of health official, in short, none other than the originator of the idea of injecting diphtheria antitoxin in the treatment of meningitis. In giving a resumé of his work this physician stated that after a most thorough trial he had concluded that the exhibition of the serum gave no results.

Of the large number of cases cited by Dr. Huber (charts were shown) and treated by himself and associates at these two hospitals, all were admitted and placed here and there in vacant beds. No effort was made to isolate these patients, and no case of contagion was reported.

Discussion by Dr. McConnell, New York.

Mr. President and Gentlemen:

I saw a great many of those cases of Dr. Huber's and everything the doctor says is quite true. There was no isolation done in any of the cases, they were all side by side with other diseases and after a trial of the diphtheritic antitoxin it was abandoned. Gouveneur Hospital is situated in the east side among east side Jews and many cases were from among these people. Dr. Huber's practice is taken up considerably among that class, also at Roosevelt Hospital. The diphtheritic antitoxin was tried very extensively; and the Board of Health tried it extensively. There was some letting up of the symptoms at the beginning of the disease, but the patient died just the same.

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A RARE CASE OF CONVULSIONS.

BY RALPH E. GALLINGER, M. D., CONCORD.

Mr. X, age 23; born in Maine; father, French; mother, half Spanish and half English; inmate New Hampshire state prison.

Entered the prison June 1st, 1904.

Did not come under my observation until last summer, when he laid off several days in his cell, apparently suffering from heat prostration, as he was employed in the boiler room at the prison. He did not again come under my observation until Wednesday morning, March 7. I then found him in bed, his temperature normal, pulse normal. He claimed to be suffering intense pain in his head and stomach. By noon he claimed the pain was particularly severe over the apex of the skull, but from his looks, I doubted his statement. I found that the preceding Tuesday while eating breakfast he had swallowed a false tooth. I ordered a cathartic and left him. His pain steadily increased during the afternoon and at 7 P. M. he went into a severe convulsion. Not being able to locate me they notified Dr. Wilkins. He was transferred to the hospital, given a hot tub and a large dose of bromides by rectum. I saw the case at 8 o'clock, Dr. Wilkins then leaving. His convulsions during the night were not more than two minutes apart. Every muscle in the body was apparently involved and at no time was there any relaxation. He was treated with bromides and chloral in large doses with no apparent effect. Several large suds enemas were given, but only the last retained; he was likewise catheterized with difficulty, but the specimen was normal. A second hot tub was given, but upon removing him from the tub he went into

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a very severe convulsion and when placed upon a blanket on the floor his position showed marked opisthotonos. Likewise two hypodermics of morphine, one-fourth grain each, were administered with absolutely no effect, not even upon the pulse nor upon the pupils. The pupils reacted to light, but the eyeballs were insensible to pressure, and upon opening the eyes the eyeballs rolled up beneath the upper lid. This condition continued until 1 P. M. Thursday, when he tried to throw off his blanket and swore about the straps which I had about his wrists. Before this at 3 A. M. Thursday the attendants thought he must be dying, for to all intents and purposes he stopped breathing. These attendants, being prisoners, had no way of ascertaining the heart's action. I might say here this cessation of breathing was marked throughout his attacks. During this time three men were constantly present to prevent his doing bodily harm, which I am positive he would have done had he not been restrained. At 6 P. M. Thursday, he began to talk freely about the strap, hands and blanket, and called for water several times, and at 7 P. M. had a convulsion lasting one minute and a half and between 8 and 9 he had a few slight convulsions, but at 9 showed signs of regaining consciousness, such as opening eyes when spoken to in a loud voice. He could not talk but could whisper; at 9.20 P. M. he wanted to pass water; he was placed on the chamber but was too weak; at 9.45 he could talk much plainer and insisted he was strong enough to go to the seat. This he did and had a large movement and likewise passed nearly two quarts of water. He talked sensibly for an hour, then he slept until 3.15 Friday morning. Between 3.15 and 3.20 he had two slight convulsions, and at 3.25 he had a severe one, and the attendant had to call for aid. Between 3.25 and 4 A. M. he had several slight ones. From 4 to 7.20 Friday morning he had probably twenty slight attacks; these were limited mainly to the arms and fingers, he was apparently trying to reach his head. He was constantly moaning and apparently suffering great pain. At 8.30 he drank a glass of milk and was free from convulsions from this time

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on. Saturday his temperature was 103 degrees, tongue very badly coated, condition very weak, said he was suffering from intense headache. Sunday and Monday his temperature remained 103 degrees. Tuesday temperature 100 degrees, tongue heavily coated, bloody dejections and complete numbness of left side. Wednesday, March 14, his temperature was normal, and he had a large clay-colored movement, in which he passed the tooth, making eight days before the tooth was expelled. He also had a large hyperasthetic spot in left groin. Thursday the tongue remained badly coated. Friday still more coated, numbness over both thighs, front and back, but not below the knees, "feels like pins and needles over hips." Saturday, March 17, severe pain over bowels, tongue still coated. Sunday sat up. Monday tongue clearing, some blood passed in movements. He remained in the hospital until March 30. He probably lost twenty-five pounds in weight and at no time claimed to be free from headache. He went to the shop March 30, but did no work. He returned to the shop each day, but on the morning of April 3 he fell from his chair and was brought to the hospital in an absolutely rigid condition. I saw him about 9.30; his pulse and respirations were good but he remained intensely rigid. I gave him double superorbital pressure, not only over the superorbital nerves but also upon his eyeballs, but with absolutely no effect. If any of you have had this tried upon you, you know what exquisite torture it is. I called for a rubber sheet, which was placed beneath the patient, and a gallon of ice water; the patient being stripped, the contents of the pitcher were poured over his head, neck and chest; not until the last pint struck him did he show any sign of regaining consciousness, then he let loose a howl which shook the window panes and promptly sat up in bed. This treatment was followed by calomel grains X, sodium bicarbonate grains X, and compound jalop powder grains X. This was later followed by an ounce of salts. He spent most of the remainder of the day in the toilet room. He rested the next day, but the following day went to work and I have not

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seen him since. His work has since been changed, as his previous occupation was tending the boilers, which he has always expected would explode at any time. He tells me that he never knew he had a nerve in his body; he gives a good family history, and says he has never been sick a day in his life from illness, but he has had two severe accidents, the first one being knocked off a freight car by striking a bridge in which he received a scalp wound, probably accompanied by some concussion of the brain, inasmuch as he was carried to a hospital in Worcester where he remained unconscious for over twenty-four hours. The scar of the scalp wound can now be seen on the left side of the scalp, but there is no depression. His second accident took place in the Philippines, when he was struck in the face by the butt of a gun, in the hands of a Filipino. For the second time he was knocked unconscious, and in this instance was carried to the company's hospital. He lost all his teeth at this time. This case is evidently one of hysteria. The number and severity of his convulsions probably numbering between one hundred and seventy-five and two hundred. The absence of relaxation between the paroxysms, the high temperature, the gastro-intestinal disturbances, the marked loss in weight and strength makes this an unique case from the ordinary one of hysteria. The fact that this man suffered intense pain in the head, the fact that he has been unconscious from a blow in the head, the fact that foreign bodies in the stomach and bowels often cause convulsions, and the fact that he was an inmate of a prison where suicides are so common, made the diagnosis of this case obscure during the beginning of his attack. I also want to repeat the length of time this tooth was retained. It was swallowed March 6 and did not pass off until March 14.

Discussion opened by Russell Wilkins, M. D., Concord.

Mr. President and Fellows:

I can add but very little to Dr. Gallinger's paper. I was the first one to see the patient in his cell and absolutely no

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history could be obtained except that he had been free from any epileptic attacks since entering the institution. I ordered him removed to the hospital. He was having these convulsions quite rapidly and between the attacks there seemed to be a condition of tonic spasm. There was nothing about his condition that assured one of epilepsy, uræmia or poison, but a certain air of obstinacy and a purpose about his movements as though endeavoring to free himself from restraint. I never saw a similar case before and do not expect to see another very soon. Another thing which would point toward its being hysterical was that on the second day he had not passed urine and had to be catheterized.

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ATROPHY OF SMALL INTESTINES, WITH REPORT OF CASE.

BY A. M. FERNALD, M. D., SUTTON.

I report this case to the Medical Society for the purpose of acquiring knowledge on this subject, as I do not find much in my text-books pertaining to this disease.

I will report the following case:

Miss H. C. R., thirty-two years old, teacher at one of our schools, called on me January 19, 1906, and gave me the following history:

Was weak and feeble when a child. When ten years old she fell from a swing, and very soon after began to menstruate. When twelve years old had brain fever, caused by overstudy and eye strain; was out of school one year. When sixteen years old had a slow fever which developed into chronic stomach trouble. At eighteen had nasal and stomach catarrh and lost flesh, and had a cough come on which they were afraid would develop into tuberculosis; but with good medical aid and nursing and change of climate she began to improve, and remained very well for sometime by being careful about her diet. About five years ago the catarrh of stomach began to be more troublesome, and she would vomit up an accumulation of mucus.

She gave me the following family history:

Brother enjoys good health.

Father's general health was very good. He contracted heart disease in civil war, from which he died very suddenly one night in 1902.

Mother's general health has always been very poor. She

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has a scrofulous diathesis, has had a great deal of stomach and bowel trouble, and suffers from indigestion; was confined to bed most all the time for one year from dysentery.

The principal thing that troubled my patient was a terrible distress in her stomach and bowels. I gave her something for distress, and told her I would like to give her a more thorough examination, as she was all dressed and ready for school. So I made an appointment for Sunday, January 21, as she was going away Saturday to a teacher's meeting.

I went up Sunday and made a thorough examination, and found pulse normal, temperature normal, respiration normal, distress in stomach and in abdomen, but principally at pit of stomach and one or two inches below umbilicus, with tenderness on palpation and percussion all over abdomen, but more at pit of stomach and McBurney's point. She has always menstruated regularly, and not very much pain; always very nervous; never had typhoid, nor any injury to abdomen. She was nauseated, and had been for several months previous; no appetite; bowels loose, with thin, watery discharges, four to eight a day, bowels distended and hard, but not tympanitic; she had complained of this distress in stomach for several months.

She had an attack similar to this last summer, that lasted a few days, and then she got up, but the distress has followed her since. I asked her where the pain was. She said it was not a pain, but a distress.

I put her in bed and gave her calomel, castor oil, etc., ice-bag over appendix. Symptoms continued about the same till about February 8, when she seemed a little better for about a week, so she sat up two or three hours a day, and ate more. Then she began to fail slowly. The pulse all through the sickness remained from fifty to seventy per minute; temperature normal most all the time through sickness; six or eight days temperature was up one or two degrees.

At first I suggested an operation for the inflammation in the appendix, but she refused.

I called in consultation Dr. N. L. Griffin, of Bradford,

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twice, and Dr. L. A. Sanders, of Concord, once. We used everything we could to stop the nausea and vomiting, but to no avail; we used high and low rectal enemas, but nothing seemed to relieve the vomiting or the distended abdomen.

The vomit was mostly liquid, tenacious mucous, streaked with a dark brown substance, but not any fæcal matter or odor any time during sickness.

Then she gradually grew weaker, vomiting increased, bowels would only move when we used enemas. The only thing she complained of was the distress and terrible sickness at her stomach. She continued to fail till 3 A. M., February 25, 1906, when she died.

At 8 P. M. that day Drs. Griffin, Underwood and myself performed an autopsy. On cutting through the abdominal wall we found considerable subcutaneous fat; we found the liver and stomach normal; we followed the intestines down till we got within about two and one-half feet of Meckel's diverticulum, when we found about two inches of the ileum atrophied, and then two or three inches normal size; then the rest down to Meckel's diverticulum atrophied, about two feet of it; the lumen was about one-fourth inch, so small that only liquid or semi-liquid could pass through it. Meckel's diverticulum was inflamed, and about one inch in diameter and three inches long. The rest of the intestine was normal. The vermiform appendix had been inflamed, but was quite normal then. There was a hard substance in the lumen. Kidneys congested, but normal size. Spleen normal. Ovaries congested and enlarged. Uterus had two fibroid tumors, each about four inches long and two inches in diameter, with a dozen or more smaller ones starting out from these larger ones.

Discussion by Dr. L. A. Sanders.

Mr. President, Ladies and Gentlemen:

I wish I had staid out a little longer. As I remember seeing this patient with Dr. Fernald a few days before she died, at which time we examined her very carefully, and it seemed

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to me and to Dr. Fernald, and we were agreed upon that point, that the patient had apparently had a mild attack of appendicitis. There seemed to be a little resistance on palpation over the right side in the region of the appendix. Examination by rectum revealed what seemed to be more or less of a mass in that region, but in the condition she was at that time neither of us felt like advising an operation. At that time, as the doctor said in his paper, the nausea and vomiting were very persistent, she having had two or three attacks during the short time I was in the house. She was not emaciated, and her color was fairly good. There was nothing to indicate that the patient was going to die in three or four days from any symptom I saw, and I was perfectly honest in assuring the doctor that I felt she ought to get over the attack and recover sufficiently to get home, and a little later have the appendix removed.

That goes to show how easily we get mistaken in those cases. The doctor wrote me later and asked if an operation at an earlier date would have saved her life. An earlier operation would have resulted in the removal of the appendix, and I doubt very much if an earlier operation would have revealed the cause of her trouble.

Discussion by Dr. A. W. Mitchell, Epping.

I was thinking of one case I saw a dozen years ago, which was very much like the history of the preceding. The patient was a man about thirty-five years of age, stopping temporarily in town. We discovered that he had a tapeworm, and relieved him of it; but this did not relieve him of the distressing condition. I kept in touch with him after he left town, and I learned that he died, and the autopsy showed atrophy of the intestine with almost stenosis. I question whether the tapeworm had anything to do with the condition or not. He did not know that he had a tapeworm, nor were there symptoms to indicate until a segment was found. Possibly the worm was the irritant. The symptoms of atrophy in another, older patient seemed clearly to follow trauma to the abdomen by the trampling of a horse.

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BACKACHE IN WOMEN.

THOMAS W. LUCE, M. D., PORTSMOUTH.

A year ago we had a most interesting paper on the subject of headache. The author very clearly described the different forms of this troublesome affection that we encounter in the daily routine of our practice, and told us how to diagnose and treat them. I, for one, obtained some very helpful hints from this paper and its discussion. This fact has led me to the choice of my own subject, and I shall have something to say about backache and more especially backache in women.

Unlike the author of the paper already referred to, I shall only be able to direct your attention to some of the different varieties of the trouble in question, and confess that as far as the treatment is concerned that I am a seeker for information and have very little to impart.

When a patient consults me with headache I usually refer him or her to Dr. Flanders, and if no improvement follows I assure the patient that it is his fault, and so extricate myself from the difficulty quite easily, but when a woman comes to me with backache I find myself with no such haven of refuge and am forced to meet the condition as best I can.

Backache in women has become a sort of professional *bete noir* with me, and I have made these few notes hoping that they may at least bring about a good discussion and enable me to learn how the other members of the New Hampshire Medical Society treat these cases.

Perhaps the first idea that comes to the mind of the physician when a woman tells him she has backache, is that she has some disease of the pelvic organs and more especially some retrodisplacement. He makes a vaginal examination and finds a sharply retroflexed uterus. There is a history of premenstrual pain extending over a long period. The

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general tone is good and a careful examination reveals no other lesion. Now the correction of this displacement by means of a properly fitted pessary or one of the various operations for uterine suspension, with a possible correctment, theoretically, should cure this case of her backache, and so he tries one or the other, and if his experience is anything like mine he does n't cure them all, and far from it. To illustrate:

Five years ago a girl nineteen years of age was brought to me by her mother, who said that her daughter had backache all the time. She was in school in Bradford and under the care of a Haverhill physician who had treated her for a long period with vaginal packs and douches. There was a history of dysmenorrhœa since the beginning of menstruation, she being always obliged to remain in bed the first day. She was unable to walk a half-mile without suffering with an increase in her backache, and the trouble seemed to be growing worse instead of better under her present treatment. I advised and made a simple suspension of the uterus, having found by vaginal examination, as I had supposed, a retroflexed condition of the organ. This gave her almost immediate relief. The backache has never returned. She is able to walk or run, dance, play golf and tennis to her heart's content; in fact, is normal without an ache or pain to-day.

About two years ago a young lady of twenty-five came to me saying she had had backache for five years or more, always had dysmenorrhœa. She was unmarried and lived at home with her parents. With the exception of a retroflexed uterus, as far as I could make out, she was perfectly normal and had a most healthy aspect. I did a central suspension in this case with a most satisfactory result as far as the operation was concerned, but with no relief whatever to her symptoms. I have since curetted her, used ichthyol packs, douches, actual cautery to the spine, anti-rheumatics and neuralgics and all of the uterine sedatives in various combinations, and still the backache and dysmenorrhœa go merrily on.

Now as far as I could ascertain from inspection and palpation inside and outside, the only abnormality in both these

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cases was the retroflexion. Both were young unmarried women, undoubtedly virgins, both living under good hygienic conditions, with a good family history. Both had the same symptoms, and the same procedure in treatment. One obtained complete relief and the other none whatever.

These cases are selected at random from many others that I have encountered, all of whom it would seem should have been cured but many have not. Undoubtedly the fault is one of diagnosis, but how to remedy this fault is the problem.

You are all familiar with the woman who comes to you and says she was always well before her child was born, but since that time she has been troubled with a bearing down feeling and backache. You examine her and find some lacerated and relaxed condition of the birth canal and a large subinvoluted uterus. You say, Oh, yes, I can relieve you by a very slight operation. A curetting with proper repair of the lacerations followed by a prolonged rest with hot douches will relieve a vast majority of these cases, but a certain percentage seemingly are not helped in any hands, and when this is the case what do you do? Generally they are tabulated under the head of hysteria, and given placebos for a time until they drift into other hands.

Now is the backache in these cases an hysterical manifestation or does it depend upon some local lesion that we fail to discover, and if the latter, how is it to be discovered, granting the uterine position, tubes and ovaries are normal?

There is a backache due to a cervical endometritis, seen in young girls, which I have found very hard to overcome. There is usually a white of egg looking discharge from the vagina, and dysmenorrhœa. The general health is below normal. Local treatment is usually out of the question. Iron tonics and a rigid hygienic regime will do very much for these cases, but a very few are cured.

As to the backache that goes with pregnancy, I have found that when a retrodisplacement exists a frequent use of the knee chest position in the early months, with a pessary or possibly a wool tampon, may do some good, but after the uterus is up out of the true pelvis I have been unable to do much

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for this symptom. The backaches that go with benign tumors in the pelvis are usually quite promptly relieved with the removal of the offending growth, unless post-operative adhesions furnish a reason for their continuing. When this occurs they afford a very difficult problem in treatment. In the inoperable malignant cases opium seems to be the only source of relief.

Most patients consulting a physician for backache believe that they have some kidney trouble, and it is a most difficult matter to convince them to the contrary, if such is not the case. This popular fallacy is kept alive by the patent medicine advertiser, who has found in it an immense source of profit. Now there is a form of backache due to diseased kidneys. With this there is nearly always a marked tenderness to be found on pressure under the twelfth rib. The relief of the symptom depends wholly upon the nature of the disease of the kindney, subsiding promptly under treatment in the simple congestive disturbances, but being very persistent in the incurable conditions. Then there are the backaches higher up, due to diseased conditions of the elementary tract and its diverticula. These pains are usually described as "piercing" or "knifing" in their character, and are spasmodic, differing from the steady aches from reflex irritation lower down. Their relief depends wholly upon removing the cause, and when this can be accomplished they promptly subside. These patients usually believe that they have lung trouble. There are some diseased conditions of the pleura that may cause lancinating pain in the subscapula region, but one must never forget gall stones and gastric ulcer when treating these patients.

The backaches due to tubercular disease of the spine usually subside under the general principles of treatment for these conditions, but not always. I have a patient now with the opium habit, contracted while undergoing really scientific treatment for Potts disease when a child.

Last but not least are the long line of neurotic and rheumatic conditions, with backache as a chief symptom. Time will not permit an analysis of these cases, but they all present a most serious proposition for treatment.

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HYSTERIA AND NEURASTHENIA.

BY L. M. KEENE, M. D., KITTERY POINT, ME.

I am aware that these are two subjects that we know very little about, but ones that should interest us all as practitioners, for we have these cases to deal with.

Möbius defines hysteria as a state in which ideas control the body and produce morbid changes in its functions.

I would hardly agree with such a definition as this, because in my opinion in cases of hysteria, sensations govern the functions of the body without any idea or thought (as a thought and an idea are one and the same).

Osler defines neurasthenia as a condition of weakness or exhaustion of the nervous system, giving rise to various forms of mental and bodily inefficiency.

I agree with this definition to the extent that the sub-conscious mind is in a weakened condition. Now that needs a little explanation on my part.

I believe that every human being has a conscious and a sub-conscious mind (if we call it a mind), but call it what you will, I believe these two conditions exist, consciousness and sub-consciousness.

The reason that I disagree with the definition of hysteria is, that to me it is a sensation that controls the body and causes disorders in its functions.

My experience has been that when you can make a patient conscious of some disagreeable thing that is going to happen, sometimes so slight a thing as the prick of a hypodermic needle, their symptoms improve wonderfully even after they are seemingly in a semi-conscious state.

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Many times when visiting patients we find them in a sort of comatose condition and I think at times it is such, but when so, it is due to an overstimulation of the conscious or sensitive mind, and when we get overstimulation of any organ or part of the body, we get paralysis.

In my opinion it is a duel between the conscious and subconscious minds and when we get paralysis of one the other predominates.

I have never seen a patient in an hysterical condition that showed much evidence of being asleep, although they might seem to be quiet after some hysterical demonstration, unless it was sufficient to cause some fatigue and then generally when they awaken the symptoms that at one time seemed grave, have all or nearly all subsided. Now a weakened condition of the body or mind due to the patient having been under a long strain from worrying over some hard lesson at school or over family affairs or business troubles, may so overstimulate the sub-conscious mind, or the one that governs thoughts and ideas, that it is unable to cope with the strain of sensations that are received by the conscious mind and then the conscious mind predominates and we get the hysterical demonstrations that are without thought, and we know that many of the unheard of things done would never have been done if any thought had been used.

For example, a child has been crossed in something and he lies on the floor and kicks and thrashes about and cries, or tries to, that, in my opinion, is what in an adult would be called hysteria, and if the child is told that he will get a whipping if he does not stop, he will generally stop.

Many of our hysterical patients if given a dose of medicine that is disagreeable, seem to improve their own conditions so that few doses have to be taken.

There is no doubt in my mind that with superstitious people of the past, hysterical demonstrations could have been interpreted as acts of some evil spirit.

For example, take the famous "Salem Witchcraft." There is no doubt that the victims who were supposed to

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have the presence of some evil power about them were none other than what we call to-day hysterical patients.

NEURASTHENIA.

We have given as a definition for neurasthenia "A condition of weakness or exhaustion of the nervous system, giving rise to various forms of mental and bodily inefficiency."

To me it seems to be a weakness of the conscious mind, and in such a condition sensory impressions become more readily thoughts and ideas.

The sub-conscious mind predominating, minor sensations are more readily picked up and become fixed ideas or thoughts and form lasting impressions that would not be, if the conscious mind was able to grasp them and realize their value.

Generally these patients are easy victims to the hypnotic power. Many are easy victims for the ideas of friends and neighbors, seemingly without being conscious of believing all they hear about themselves and their condition.

Discussion by J. H. Neal, M. D., Rochester.

Mr. President, Ladies and Gentlemen:

I was not aware that I was down to open the discussion of this paper until I saw the program. I met the author on the train this morning and called him down for not having sent me a copy. He then offered me his paper that I might read it while on the train between Rockingham Junction and this city. I refused to look at it. I do not wish to offer this as an excuse for not being prepared to discuss it. Had I seen and read his paper and had plenty of opportunity to look up the literature concerning neurasthenia and hysteria I should not have prepared myself for this discussion.

The session of the meeting of the New Hampshire Medical Society is too short for any man to present the contents of his library. We are here as physicians in actual practice, what

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we have gained from experience is what should be used in our discussions. We have no time to devote to exploiting the opinions of authors or would be authors.

The author has read a very concise paper upon neurasthenia and hysteria; volumes have been written and days could be consumed in the discussion of these two diseases or conditions. It is impossible to review the theories concerning the causes of neurasthenia and hysteria.

In regard to the treatment of neurasthenia I believe that any form of treatment which is routine is very likely to be injurious to the neurasthenic. The neurasthenia can be increased by too many rules and regulations concerning treatment. The first essential when a neurasthenic patient presents himself to the physician is to eliminate every possible source of irritation before the physician concludes that he has a case of simple neurasthenia.

We are not all born with the same amount of nerve energy; some are born nervous bankrupts, others have a vast amount of reserve nerve force. They can be compared to reservoirs of water. A small pond with twenty-foot head will start a water wheel and with as much power as a vast reservoir with thousands of acres, with the same amount of head. In the first case the wheel will move for a short time, until the reservoir is exhausted; in the second case the wheel will move until the reservoir is exhausted. When the two are exhausted nothing can be done until the reservoirs are partially filled at least. One will produce continuous power, the other power for short periods, and so it is with the neurasthenic. He can do for a short time and then becomes exhausted and must wait until he has gained a supply of nerve force. On the other hand, a man born with a vast amount of reserve nerve energy is constantly moving without exhaustion.

I am convinced that local irritations are the causes of many cases which are diagnosed as neurasthenia and that neurasthenia is simply the result of the local condition. I will relate briefly the history of a case which has come under my observation recently:

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It is that of a lawyer. About two years ago another physician and myself told the lawyer that the symptoms of which he was complaining were due to difficulty with his eyes. He was complaining of difficulty with his head, his digestion, had no confidence in himself, he did not dare leave town, fearing that he would lose consciousness and not be able to return. He could not read thirty minutes under any conditions. During the past three years he has consulted three oculists. They have all told him that he had some disturbance with his eyes but not enough to produce the neurasthenia from which he was suffering, and each diagnosed his case as neurasthenia. He came into my office about twelve weeks ago and told me that he thought he had appendicitis. I examined him and found no evidence of appendicitis, and after talking with him for sometime I again told him that the difficulty was with his eyes. He could not believe that such was the case and he had very good reason to believe that I was in error after the experience which he had had with the oculists. I was stubborn enough to insist that his eyes were to blame. He asked me if I would take him to some good oculist and have the matter settled. I did so. The oculist discovered the defect and fitted glasses to his eyes. He has told me within a week that he is perfectly well. He has gained fifteen pounds of flesh, has no trouble with digestion, can read as long as he desires.

Discussion by Dr. G. H. Guptill, Raymond.

Mr. President:

The remarks of Dr. Neal as to the causes of neurasthenia recall to my mind a case which bothered the life out of me several years ago and whose history I am not going to weary you with at present. I was a young man then just commencing practice and had plenty of time to devote to her troubles. I never worked harder in my life. I watched the case carefully for quite a period of time. One day the mother made some remark about worms. This girl was at

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this time twenty-one years old and had, as I supposed, passed the "worm period." But in sheer desperation I gave her a big dose of sanctonin and calomel with the result of two large round worms thirteen inches long. She has had no neurasthenia or neurasthenic symptoms since that day. I do not really believe that the worms in the stomach caused all her symptoms but I believe this to be a cause which will certainly do no harm to take in consideration.

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THE PHYSICIAN'S DUTY TO THE PEOPLE.

BY A. E. GRANT, M. D., DURHAM.

It has been a most difficult task for me to decide upon a topic which I thought would be acceptable and worthy of the time of consideration by this august body, and one which would in any way advance our cause of usefulness, and bring to our minds more clearly our obligations as representatives of our noble profession.

I wish that I might be able at this time to present an infallible remedy for the cure of the many now incurable diseases, or recommend and describe in detail the technique of some yet unperformed surgical operation for the relief of suffering humanity.

Not being able to do this, it is a great comfort to realize that the relief of human suffering is not wholly accomplished by medicine and by the knife. Bringing to mind the topic, "The physician's duty to the people," it is safe to say that his principal duties are to prevent and relieve suffering in whatever way he may be able to do it.

One might think that his duty was wholly to relieve the suffering of the body as pain, but this is only one branch of his many duties. His administration of drugs, his manipulation with instruments, are but a small part of what is required of him if he fulfills his whole duty to mankind.

It seems to me that one of the greatest obligations of the physician to the people is to be a teacher. One of the most potent factors in the relief of human suffering is by enlightening and educating the people so that they will refrain from doing those things which produce and augment suffering, and

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understand how to do those things that will relieve suffering. Not that the physician should enter into prolonged discussions of physiologic problems, or discuss diseases and treatments with the laity, but every physician has many opportunities to act as an instructor to the patient and his friends, and set their minds in the right direction upon subjects in which they show gross ignorance.

For instance, a few years ago a lady who is considered an intelligent woman came to my office and wished me to send some medicine to a friend of hers, whose child had whooping-cough, to "break it up," saying that Dr. A. some years ago had given her something for her children to "break up" whooping-cough at the beginning of the disease.

This summer I was asked by a parent if I could not give something to prevent their child from taking the measles, as Dr. B., some years ago, said he could give something as a preventive. The number of cases of typhoid fever and pneumonia that have been "broken up," and the number of people who have visited the physician "just in time" to save their lives are truly wonderful.

Such statements as these from physicians to the people will never educate them very much, and is it any wonder that the laity are ignorant about these matters when a physician in whom they have confidence instructs them in that manner? Is it any wonder that there is a restless, unsettled, distrustful condition of mind among the people, and especially among patients who have chronic diseases and have gone the rounds, and "have suffered many things from many physicians," and been instructed differently by each one? While our schools and colleges are spreading general knowledge and education in a most admirable manner, yet there is a vacancy which no one but the honest physician can fill.

I believe the ignorance of the people of the present time and of ages past is, and has been, in a great measure due to the ignorance and *untruthfulness* of the physicians, and probably more to untruthfulness than to ignorance. Superstitious beliefs and fads have been inherited and handed down

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from generation to generation, and so inbred in the young of each succeeding generation that they seem to them like realities and truths. It is wonderful with what tenacity a certain proportion of people in this enlightened age, in the midst of education and refinement, still cling to the old and superstitious beliefs of the past ages. By this I mean their faith in charms for good or evil for preventing and curing diseases, such as electric belts, eel skins and leather straps around the waist to cure kidney trouble and backache; brass rings around the finger and horse chestnuts carried in the pocket to prevent rheumatism; skeins of flax around the body to prevent mumps from "turning down;" red strings around the neck to prevent nosebleed; camphor and asafœtida suspended from the neck to prevent infectious and contagious diseases; repeating certain magic words for the relief of pain. The howling of dogs at night under a patient's window, and the hooting of an owl, the tick of the "death watch" (an insect under the wall paper) are regarded as grave and sure precursors of death. The fear of certain days, as Friday, and certain dates and numbers, as thirteen, and many other equally absurd things. Mental Healing, Christian Science, Dowie's Touch are fads of modern type. For nearly all of these beliefs which the people entertain the physicians of olden times were responsible. For it was through their ignorance or untruthfulness, and perhaps both, which first introduced many of these beliefs to the minds of the people as facts, or at least if the physicians did not introduce them to the people, they did nothing to dispel them from their minds.

The people of the present time who believe in these things do not understand how these charms work or why they produce such and such effects, but somehow, and in some mysterious, unknown way, they believe in their mighty power; and as Lord Bacon said in regard to the "Weapon Ointment Cure," we must accept the facts and leave them unexplained. The people of past ages did not understand how the charms worked. The workings of the physicians and surgeons seemed to them like something supernatural. The instru-

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ments and medicines were a dazzling mystery in their eyes. The words of the physician were to them almost as sayings from the gods.

It was this false pretense on the part of physicians, this veil of mystery, which kept the people seeking for something that was more mysterious, and the quack in those days, as at the present time, who could present the most dazzling mystery was the one most sought. It is wonderful what magic there is in mystery.

I believe the only way to suppress the curse of patent medicines, to starve and retire the quack from business, is to educate and instill good common sense into the minds of the laity, so that they can see for themselves that there is nothing supernatural about the practice of medicine and surgery. They should be taught that patent medicines are nothing but drugs secretly compounded, that superstitious beliefs and fads are entertained only by the ignorant, and that they are false and have no power.

It is a fact that all will admit that our best patients, easiest to treat, are the ones who are the best informed. They are the ones who will call the physician first, they have the most confidence in him, they consult the quacks least, and buy the least patent medicines. They do not expect a physician to leave half the medicine which he has in his case when he is called to visit them, and they are just as willing to pay if he leaves no medicine.

The time has fully come when the physicians should cease standing out as a wonder, as something almost supernatural, when his medicines, his instruments and his acts are shrouded with mystery. The sooner the people can be made to realize that the practice of medicine is a science, and based upon common sense and facts like any of the other arts, the sooner will they employ and appreciate the services of the honest physician. The people have a right to expect the physician to be accurate in diagnosis, painstaking in prescribing, and to use every source of information that may be made useful in the cure of disease and the relief of human suffering

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and saving of human life; to be kind to the poor, sympathetic with the sick, courteous and honest to all men.

If every physician would try to eliminate from the minds of his patrons all that mystery and superstition which has clung to the average person since his childhood, and endeavor to influence and instruct the child so that correct ideas will be rooted in their minds in place of superstitions and fads and ignorant beliefs, a greater change in the practice of medicine would take place in the next century than there has in the one just passed.

It is with the young that our efforts will be most effective. The young are the future makers and owners of this earth. Their physical, intellectual and moral condition will decide whether the world will advance in civilization and morality, or become more criminal and immoral. For their education and training and capabilities the physicians, as representatives of the medical science and art, and as teachers, should become responsible. It is in infancy and childhood, before the dangerous period of puberty sets in, that habit and character for good or evil are formed. It is at this period of life that they are most receptive to good instruction.

The physician's duties to the people are legion. He is concerned with the new individual before he is born, while he is being born, and after. The physician is called upon to assist in the regulation of labor laws, factory legislation, and the prohibition of marriages of epileptics, syphilitics and criminals. He is called upon to advise in the manufacture and distribution of food stuffs. His advice is sought in the construction of schoolhouses and public buildings, and in all hygienic and sanitary questions.

We have seen many exhaustive articles in our medical magazines recommending some legislation in regard to prohibiting marriage between epileptics, syphilitics and criminals, but thus far no legislation has been enacted in any states except Michigan and South Dakota with regard to the inebriate, whose condition is as much a disease as epilepsy or syphilis, and who is the father and mother of thousands of

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epileptics, idiots and criminals. A move in the right direction, however, has been taken by various temperance organizations in different localities by employing a competent physician whose duty it is to visit the schools and give instruction in regard to the effect of alcohol upon the human body, believing that it is through the children that this perplexing problem of intemperance is to be solved. And may the time be not far distant when there shall be no such thing as intemperance or syphilis, and when there shall be no epileptics, idiots or criminals, and when the people shall have replaced superstitious fads and ignorant beliefs with knowledge of truth, and shall have become so educated that they shall know the value of *true* professional services.

Discussion opened by Dr. Fairbanks, of Boston, Mass.

Mr. President and Gentlemen :

I am not a member of this Society, but I should like to say a few words because I think the subject is one of importance. I think we have all found it exceedingly hard to educate the people in physiology and anatomy.

For years, in Massachusetts, they have made a pretense of teaching children physiology in the public schools. The fact that it was being taught was, however, taken advantage of by prohibitionists to introduce into the public schools propaganda against the use of liquors and tobacco. Now, it may be wise to inculcate in the children a knowledge of the evils of the intemperate use of liquor and tobacco, but I do not believe it should be mixed up with physiology; yet, almost every text-book is filled with it, and to the child of average mind the chief idea of physiology he gets is that alcohol and tobacco are the most poisonous things in the world. This is pathology, not physiology, and I do not believe it should be taught with physiology. I believe that this has been a great handicap in educating the people in true physiology and anatomy.

I have frequently given a great deal of time to patients in

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going into the details of their cases, explaining to them the nature of their trouble, and have found afterwards by some chance remark they have made that they had not comprehended the subject in its smallest detail. I believe that the foundation for the proper education of the public in the laws of health and disease must be started in the public school in the proper teaching of physiology and anatomy.

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REPORT OF CASE OF TUBERCULOSIS OF URINARY TRACT.

BY J. W. COOLIDGE, M. D., BRISTOL.

This is a case of tuberculosis of the urinary tract, which came under my observation May 18, 1902, giving the following history.

Woman aged 59. After ten or more years of married life, having no children, her husband died, in 1876, of "consumption." Mrs. A. was never of strong, rugged health, and was sick for some time after her husband's death. Disease unknown.

From this time until 1897 she had several attacks of nervous prostration. She was one of ten children, two or three having had nervous troubles.

In 1897 she began to be troubled with cystitis. She had private treatment by physicians of Dover and Somersworth, until some time in January, 1900, when she went to the homeopathic hospital of Boston for treatment. Just what the symptoms or treatment at this time were I have not ascertained. But she had something for an operation, under etherization. This seems likely to have been cystoscopic examination of bladder.

Bacteria taken from the urine at this time proved by inoculation on guinea pigs to be T. B.

She was not satisfied with her gain in the hospital and left April 19, 1900, coming to New Hampshire. She had some treatment, though intermittently, from now on by Dr. E. T. Drake, of Franklin. Through the kindness of Dr. Kingsford I have a copy of the report on her urine while under Dr.

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Drake's care, with the following result: Phys. Exam.—Transparency, cloudy; color, L. amber; sp. gr., 1018; chem. reac., acid; quantity 24 hrs., 900 c. c. Chem. Exam.—Urea, .017; chlor., 9 per cent.; phos., 7 per cent.; sulp., 1 per cent.; albumen, 1 per cent.; sugar, none; bile, none; sediment, heavy thick white, few red cells, many pus cells, few large round cells from bladder. Diag.—Pyelitis or cystitis, probably cystitis.

Her condition at my first visit, May 18, 1902, was as follows: Face a little bloated, while feet and legs were shiny and hard to middle thighs. Heart irregular and varying in volume of blood propelled, though no valvular defects were noticeable. She sat up the greater part of the day. No headache, appetite variable, bowels constipated, and slept poorly. Treatment at this time was tinct. digitalis m. v to viii, t. i. d., tinct. chloride of iron m. v, t. i. d., elaterium gr. $\frac{1}{8}$. Tablet one each night. The last named drug was continued for some time intermittently, although she was troubled some with hemorrhoids.

May 20 I examined her urine: Sp. gr., 1010; sugar, none; albumen, in quantity; reaction, neutral; color, N. The digitalis was changed once or twice to strophanthus, but most of the time digitalis has been given, for the last year only three m., t. i. d.

She seemed to grow gradually weaker and I advised her staying in bed, which she has done since Sept. 30, 1902, with few exceptions. She was naturally of a nervous temperament and has grown more so as the disease has progressed.

In December, 1903, her digestion weakened so that she lost several days' nourishment and her mental balance was partially lost, never quite returning to the normal again.

Again May 21, 1904, her stomach failed to do duty, and now for the first time she had some headache, becoming more irrational, thinking she was not at home and that her sister was not taking good care of her; she grew steadily worse mentally for two or three weeks, leaving the house one

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evening, going down the lawn and jumping off the bank wall in her night robe and barefoot.

About this time another sister was with her for a few weeks. This she has never remembered, although at any time she could tell all about any acquaintance as well as ever; also remembers perfectly well going down the lawn and over the bank wall. Her heart at this time had a loud murmur and seemed to be failing rapidly.

July 31 began a comatose state, lasting forty-eight hours. On rallying from this condition she was given one-eighth grain morphine three or four times daily, with the idea that she could not live long and had better be comfortable and quiet.

After this she gained daily until by August 13 she was fairly rational and kept improving till nearly as well as the previous winter, remaining this way during the winter of 1904–05.

She is now a little more talkative than formerly and sometimes says something not quite right, otherwise should not notice she had changed from when I first attended her. At present she has no edema anywhere unless she sits up more than half a day. Dr. Kingsford examined the urine June 7, 1905, with this result:

Phys. Exam.—Transparency, cloudy; color, pale straw; sp. gr., 1010; chem. reac., st. acid; quantity 24 hrs., 1750 c. c. Chem. Exam.—Urea, .214 gr.; chlor., 7 per cent.; phos., 1 per cent.; sulp., 0.5 per cent.; albumen, $\frac{1}{5}$ per cent.; sugar, none; bile, none; sediment, large amount of pus, many cells from kidney, no casts, no T. B. from slides. Guinea pigs inoculated. Diag.—Pyelitis probably. Tuberculosis.

Since the above was written in June, 1905, Mrs. A. has had no special acute mental changes.

She was at my private hospital two weeks in August, sitting up about half a day, sleeping and eating well. She has had very little edema in the last year but grows some weaker and much more peevish.

On March 20, 1906, she came to the hospital for one

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month. She was drinking large quantities of cold water, which soon deranged the stomach, resulting in a bowel trouble for two days, leaving her much weaker and with her freakish appetite intensified, teasing incessantly for cold water, which had to be withheld from her.

Her mind has gradually weakened until she did not seem to realize when she was telling the truth or otherwise, and this in a woman who was once truthfulness itself. She has taken no drugs to speak of for months. Her heart sounds were normal and pulse of good character.

She has been lying in bed mostly of late, has left off most all of her reading, appearing to think only of food and water, complaining that her food is never quite right, although no one could have better care or more thought used as to what would please her.

There has been as the days went by a little edema in the lower extremities and face, the heart seemed slightly more feeble.

About June 1, 1906, she began to care less for food and water, sleeping more of the time. Soon the appetite failed entirely and she died June 8.

I did an autopsy the following day. The bowels and stomach appeared to the eye normal. The bladder contained a little urine and pus, its walls were thickened and no normal looking tissue was to be seen on the inside.

The kidneys were about the normal size, but nodular and soft in spots; in removing the right one, a soft spot was ruptured from which oozed yellow pus. The kidneys were covered with fat as well as a good layer on the abdomen.

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LOBAR PNEUMONIA.

BY C. E. HIGHT, M. D., MILAN.

Lobar pneumonia is an acute disease, in which a specific parasite invades the air cells of one or more pulmonary lobes, where it grows in a fibrous medium exuded from the functional capillaries and generates a toxin that infects the general system.

The lung differs from all other structures in having two separate circulations—the nutrient supplied from the left side of the heart through the bronchial arteries, and the functional, supplied from the right side of the heart through the pulmonary. This double circulation underlies all the phenomena of pneumonia, for without it the disease could not exist.

During the past eighteen months there has been a great amount of work done upon this disease, now recognized as one of the most important of the infectious diseases in the temperate climates. Attention was drawn last year to the alarming increase in pneumonia. There was also an increasing tendency to regard the disease as contagious, and to require isolation of the patients. This idea does not specially appeal to me, although reports are numerous, yet relatively rare, of such contagion. The reasons for doubt are, that in view of the great frequency of pneumonia, instances of contagion should be of daily occurrence instead of being exceptional. The disease is being constantly treated in the home, and yet examples of multiple cases in the same house are rare.

Also numerous authors have in the past reported upon the large number of normal individuals who have in their respiratory passages the causal organism of this disease; indeed,

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it has been shown frequently that the same organism is present in the deepest portion of lung in freshly slaughtered animals; hence to limit its diffusion by the destruction of the sputum of patients, as is done with tuberculous sputum, seems hopeless, unless the sputum of all human and domestic animals is also destroyed.

It is conceded that pneumonia is due to a specific micro-organism, the micrococcus lanceolatus, diplococcus pneumoniæ, micrococcus of sputum septicemiæ, discovered in 1880 by Sternberg, and its causal relation to pneumonia demonstrated by him a few years later. It is of great importance, both from the point of view of the pathologist and the therapeutist, that a clear differentiation should be made by the general practititioner between that form of pneumonia in which the exudate is croupous or fibrinous and due to infection by this specific organism, and that form of pneumonia not due to that specific infection. In the first disease we have a plastic exudate poured out into the vesicular spaces of the lung, which readily undergoes resolution with the development of crisis; while in the catarrhal form, the primary pathological process consists in an inflammation of the peri-bronchial tissues, and by extension of this process enough lung is involved to cause the characteristic signs of consolidation. From the standpoint of bacteriology, pathology and morbid anatomy, the two diseases are as different as two diseases involving the same structures can be. Their only point of semblance is that both give the physical sign of dullness on percussion. The two maladies are so utterly different that in some directions, at least, their management must vary greatly.

The Registrar General's report showing the relative number of deaths per million from pneumonia, typhoid, diphtheria, small-pox, measles and scarlet fever, proves that as many die from pneumonia as from all those others. Taking all ages and both sexes, the deaths from pneumonia amount to five and six-tenths per cent. The combined statistics of three observers show that in a population of thirty million,

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no less than two hundred and twenty thousand eight hundred and thirty suffer annually from pneumonia, and of these, thirty-one thousand nine hundred and fifty die of it. Coming to our own state, statistics show that there were thirteen thousand three hundred and thirty-nine deaths from this cause during the twenty years beginning in 1884 to 1903 inclusive. During the same period the increasing ratio of mortality has been beyond the increase in population. For the last six years in the same twenty-year period, the annual mortality was greater than that from consumption; from the former there were annually seventeen deaths to each ten thousand, and from the latter only fourteen and thirty-one hundredths to each ten thousand population.

The profession and the public all believe in the influence of meteorological conditions in the causation of pneumonia. This aspect is very difficult to discuss and requires masses of data to elucidate. Anders has made such a compilation during the past year, and reaches the following conclusions upon the influence of weather conditions upon lobar pneumonia:

1. Seasons exert a marked effect upon the prevalence of lobar pneumonia, the maximal mortality being observed during winter and spring months.

2. Insular climates probably manifest the greatest rise in pneumonia mortality in winter, while that of continental climates coincides mainly with spring.

3. The mortality of the epidemic form of the disease is, to a less extent, influenced by seasons, and may occur in the fourth and even the third quarter of the year.

4. An apparently close relationship exists between periods of low temperature and death rate from pneumonia.

5. Mortality rises and falls with barometric pressure, the maximal level being reached during periods of highest pressure, and vice versa; that the barometric pressure, however, is governed by the temperature, being inversely as the latter, is to be recollected.

6. The average velocity of the winds and the death rate from this disease, would appear to stand to one another in the relation of cause and effect.

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7. The coincidence of existing low temperature, high barometric pressure, the direction and velocity of the winds, and the maximal mortality from pneumonia, is so uniformly constant as to warrant serious consideration, and suggest a close and direct relation between their combined influence and the progress of mortality from pneumonia.

8. The mean relative humidity of the atmosphere shows equally decided variability, during the period of abeyance, in the prevalence and fatality of the disease, with that of the cold or annual pneumonic season.

9. The major influence exerted by the seasons, however, is probably not direct, that is by a lowering of the bodily resistance due to the low temperature, high barometric pressure, direction and velocity of the winds, etc., but indirect, by bringing about the effective element in the causation, concentration, and increased virulence of the specific poisons, in consequence of closed doors and windows and lack of free ventilation.

It would seem that of these conclusions reached by Anders, the last is the most important, and so far as our present knowledge goes, contains the gist of the matter. Fortunately this is the only influence under our control. The temperature, direction and velocity of the winds, are independent of us, but we certainly can avoid the overheating and underventilating of our rooms.

Much in the way of prophylaxis can be done in this way, far more than can be accomplished by the isolation of our patients. Individual resistance to infection can be increased by leading proper lives, living and sleeping in cool, well ventilated rooms, and by avoiding overeating, overdrinking, and overworking. In a series of four hundred and forty-four cases, twenty-four and eight-tenths per cent. were engaged in outdoor work and seventy-one and six-tenths per cent. were indoor workers.

The treatment of pneumonia, a positive diagnosis having been made, is a subject of much importance. Our text-books admit that there is no remedy or combination of

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remedies that influence the course of the disease in the slightest degree. Called to a case of pneumonia, what can the physician do? Simply combat the dangerous symptoms and make the patient as comfortable as possible. The patient's life then depends upon the extent of lung involved, the virulency of the infection, and his susceptibility to the influence of the toxins generated.

During the past five years I have treated eighty-five cases of lobar pneumonia, and only one case of broncho-pneumonia. My youngest case of lobar pneumonia was a child of about five months. Of the series, nine died and seventy-six recovered. In almost every instance I begin treatment with calomel, ipecac and soda, followed by a saline. If, at this time, the patient has a full, bounding pulse, and is not beyond the stage of congestion and hyperemia, that is, if exudation has not taken place, aconite should be administered every twenty or thirty minutes until the pulse is relaxed and skin moist, together with hot mustard foot bath and cold compresses over the area of chest involved. Venesection at this stage seems to me to be contraindicated.

With beginning exudation, the treatment is simply expectant. Interference medicinally must be for the purpose of dealing with some special symptom or complication. Undue interference to the extent of fatiguing, exhausting and distressing the patient should be avoided. This tendency arises from the fact, that, in a serious case, the friends expect us to treat it energetically. The other contributing factor is the nurse. In every country town there are one or more old ladies, kind hearted and very sympathetic, who always know just what to do in sickness, the neighbors say; many of them have had a large amount of experience in nursing. These women are particularly unfitted to care for a case of pneumonia; they fuss and putter around the room, talking all the time, in spite of all that can be said, and thus materially contribute to the exhaustion of the patient. Good nursing and good feeding are the best treatment for pneumonia.

Sleeplessness at this period is a very common sympton, and

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may be due to hyperpyrexia, profound toxemia or exhaustion, and before prescribing one should determine which condition is responsible. I believe by properly combating the hyperpyrexia with cold to the head and chest, with such other antipyretic measures as are safe; the toxemia, by actively eliminating through the bowels, skin and kidneys; exhaustion, by stimulation, much can be accomplished without hypnotics. I remember of giving one patient, a woman weighing less than one hundred and twenty pounds, as much as fifty ounces of whiskey in twenty-four hours, which was, I believe, entirely oxidized, as there was at no time the odor of alcohol on the patient's breath. When stimulation is required, alcohol is the best remedy alone, or in extreme cases combined with strychnia, strophanthus or caffeine, as seems best to suit the particular case. The condition of the pulse will help determine which is best. If the vasomotor system is relaxed, as evidenced by soft, rapid pulse, with cool, clammy skin, belladonna is indicated, and in proper cases it is wonderful to note the improvement.

If, on the other hand, the condition is due to venous engorgement, with failing right heart and pulmonic circulation, then vasomotor dilators may relieve, by dividing the blood more equally between the arteries and veins. It is at this stage that venesection offers more than any other measure; the dyspnœa and cyanosis are magically relieved and toxine gotten rid of. Venesection associated with saline infusion in this class of cases acts well. The infusion is powerful heart stimulant, and should be used unless there is associated pulmonary edema, in which case it is contraindicated.

Digitalis has not been of much service to me in pneumonia; it does not act well in presence of fever; if given by stomach it is very irritating, and it raises arterial pressure and thus increases the work of the heart, at the same time favoring venous congestion by lessening the capacity of the arterial system.

Pain is not a rare symptom and may produce sleeplessness, unless attended to. In mild cases hot or cold compresses with

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sinapisms are usually sufficient, or strapping the side with adhesive plaster may be resorted to. Morphine would be contraindicated were one lung solidified and the other the seat of hyperemia and edema, with more or less mucus in the bronchial tubes.

Delirium is due to the same general causes as sleeplessness, and the same measures apply to its treatment.

As a rule the temperature needs but little attention. Indeed, it has been proven by experimentation, that the toxin of pneumonia, when heated to a temperature higher than the normal of the animal injected, caused a much more rapid development of antitoxin than when not so heated. Hence it has been reasoned that the high fever associated with the absorption of the toxins from the seat of the disease, produces an effect similar to that obtained by heating the toxin before injection; that is, that fever in some way aids the body in acquiring immunity by the formation of antitoxin. If fever has no relation to the process of immunization, it is curious that the fall of temperature and completion of immunization should occur simultaneously. Looking up reports, I cannot determine that the mortality is affected by temperatures going up to one hundred and five degrees.

Tympanitis has been present in about ten per cent. of my cases. In two fatal cases, it was very marked and I was unable to relieve it. It is usually due to faulty feeding, and can much more easily be avoided than relieved; or it may be due to vasomotor paralysis, occasioned by the general toxemia. Obviously the use of calomel or cathartics at this stage must be contraindicated, and vasomotor stimulants used. Ergot in large doses hypodermically has given best results in most cases.

Feeding the patient is a matter of much importance. Feeding the patient too much is productive of much harm. Digestion is much enfeebled, and only such foods as are easily digested and readily absorbed, are suitable. I believe that milk should never be given to an adult as a routine diet; there are people who in health cannot digest milk; it is too voluminous and contains too little carbohydrate.

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The diet which has proved most satisfactory in my hands is very simple, egg albumin and grape sugar. In fever there is an increase in output of both nitrogenous and non-nitrogenous waste products. Now if we undertake to supply carbon and nitrogen in the proportions in which they are thrown off, and how can we better help our patient to withstand the ravages of the disease, what will a proper diet consist of? Physiology teaches that the ratio of carbohydrate to proteid in a correctly proportioned diet is approximately sixteen to one, and I cannot learn that the ratio is materially changed in pneumonia, but inasmuch as all proteids contain carbon, the ratio is reduced to three to one, that is, three ounces of carbohydrate should be taken to every ounce of proteid.

The most available form of carbohydrate is grape sugar. This alone is too nauseous, but combined with a flavor, such as raisins, is very palatable. By pouring boiling water on half its bulk of raisins and stewing two hours and filtering, a solution of approximately ten per cent. grape sugar is obtained. This, combined or alternated with egg albumin, forms an ideal diet; it contains a maximum of nutrition in an easily assimilated form, with a minimum of bulk and residue, the grape sugar requiring no digestion, and the albumin being easily digested, and figured on the above basis of proportions, about three times as much of the grape sugar as egg albumin is required. The total amount given in twenty-four hours must depend upon the condition of the patient's stomach.

In concluding, let us not put too much faith in drugs, but secure the best possible nursing, feeding, and surroundings for our patients. Secure in each twenty-four hours, three intervals, at least, of three hours rest, during which time the patient shall be surrounded by every possible measure productive of sleep.

As regards the temperature, if the patient was previously healthy and the case is running a normal course, it should not be unduly interfered with.

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Great care should be taken that the patient remain absolutely recumbent, and under no circumstances put an increased strain upon the heart by attempting to sit up or get out of bed.

I believe the serum treatment is destined to become standard treatment of pneumonia, depending upon the further perfection of bacteriological technique and the development of such sera as shall be applicable to a given case, be it of pure or mixed infection.

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THREE CASES OF PSITTACOSIS.

BY H. N. SCOTT, M. D., WOLFEBOROUGH.

These cases are of interest on account of their rarity.

Friday, November 27, 1903, I was called to see Mrs. J., a young woman in the employ of Mr. M. She was having intense pain in the region of the right scapula. The temperature was 102 degrees, tongue furred. There was nausea and constipation. She had been ill two days, but had been able to work the previous day. The pain continued several days except when controlled by medicine. The temperature varied from 102 degrees to 103½ for a week, when it subsided, and at the end of ten days she came down stairs. The next day, however, she was worse. The temperature arose to 102 degrees, remained above that for three or four days, when it again became normal, and at the end of three weeks from the time she was taken sick she was doing light work around the house. Constipation was present during the whole time of her sickness. There were no bronchial nor pulmonary symptoms.

When I made my second visit I was asked to see Mrs. M., a woman about sixty-five. She had a furred tongue, nausea, anorexia and constipation. The temperature was 100 degrees. The next day the temperature was a degree higher. Some bronchitis was present; other symptoms as on previous day. Prostration was marked for so short a sickness. She was confined to the bed.

At this time I found Mr. M. with about the same symp-

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toms as his wife had had on the previous day. In each the symptoms rapidly increased in severity. Wednesday, December 2, Mrs. M.'s temperature was 103 degrees, pulse weak and rapid, mind wandering. Mr. M.'s temperature that evening was 104½. Until then he had remained up to care for his wife, but gladly went to bed when a nurse arrived.

From this time to the end of three weeks Mrs. M.'s temperature varied from 101 to 104 degrees, when it became normal. For the first week the respirations were about normal. They then arose to thirty, and for the next two weeks were between thirty and forty a minute. Moist rales were heard over both lungs, but marked consolidation was not found. Prostration was so extreme at times that normal saline and adrenalin, besides the usual heart tonics, were injected. After the crisis she gained slowly and steadily.

For the first twenty days Mr. M.'s temperature varied from 100 to 104½ degrees; the pulse from 95 to 120. Respirations only slightly increased, and never arose above 28 a minute throughout the disease. As in both the other cases there was constipation.

The twentieth day at 11.30 P. M., he had a severe chill. The temperature fell to 95 degrees. At one time in the axilla it was below 92 degrees. Hands and feet were cold; pulse rapid and at times almost imperceptible. Cheyne-Stokes respirations most of the night. At one time breathing was arrested for thirty seconds. Nitro-glycerine, atropine, strychnine, normal saline and adrenalin were injected hypodermically. Whiskey and champagne were given freely, and oxygen inhaled. The next morning the temperature was normal and remained there or above until evening, when he had a second chill with the same low temperature. Under similar treatment he rallied, but more slowly than before, and it was twenty-four hours before the temperature reached normal. From that time he gained steadily.

December 2, I called Dr. S. P. Getchell, a physician of large experience and an excellent diagnostician, who from that time was associated with me in the treatment of the cases.

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The only member of the family who was not sick was Mr. J. (the husband of the domestic), who lodged in the house but took his meals elsewhere. Careful inquiry satisfied us that the disease was not caused by the food. The plumbing was perfect, excepting that the kitchen sink was not trapped, and the end of the pipe as it entered the sewer was above the water. As this condition had existed for several years we did not believe it had caused three cases of serious sickness to occur within two days of each other.

A trained nurse who had had a large experience in typhoid fever came that night. To her, I said: "These cases are probably not typhoid fever" (at the time I think she doubted the statement), "but treat them as though they were.

A few days later Dr. Cook, of Concord, saw the cases, and again the cause of the disease was sought for without success. Blood from Mr. and Mrs. M. was taken to the Concord laboratory and examined for typhoid and malaria, with negative results.

December 11, Dr. Herman F. Vickery, of Boston, Mass., was called. He took back with him some blood which was examined by Dr. Oscar Richardson of the Massachusetts General Hospital, for malarial, typhoid and para-typhoid fever, again with negative results.

December 16, Dr. Vickery made a second visit. Up to this time the most we had done in the way of diagnosis was to find that it was not one of several diseases which in some ways it resembled. In course of the conversation I said: "Mrs. M. has always thought that the disease was caused by the parrot which died a few days before they were taken sick." "Ah!" said Dr. Vickery, "That is interesting. There is a disease caused by parrots called psittacosis." I confess that I had never heard the word before, but it proved to be the key that unlocked the mystery.

Two weeks and a half before the commencement of the sickness, Mr. and Mrs. M., who were in New York, sent home a parrot. When they came home a few days later, it was sick with a bloody diarrhœa. It was kept in the sitting

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room where the family spent most of their time, and was carefully cared for by Mrs. M. and Mrs. J. It died four days before the commencement of their sickness. I could find but slight reference to the disease in my library.

Dr. Vickery, however, looked up the subject in the Boston library and kindly sent us literature upon it. No case occurring in the United States was reported. In Europe several epidemics are reported, the first being in 1879. In Paris seventy cases are reported as occurring between 1891 and 1896, forty-nine of them being in 1891, of which over one third died. Similar epidemics occurred in Florence, Genoa, and other cities, with an average mortality of over one third.

The disease commences with a high fever (all of these did). Relapses are common (occurred in the case of Mrs. J.). Bronchitis is present in a large proportion of the cases (occurred in a severe form in two of these). A majority of the cases have pneumonia. Constipation was a marked symptom in all of these cases as it usually is, though some cases reported had diarrhœa. The ending in psittacosis is usually by lysis, but in two of these it was by a very marked crisis.

There was at no time petechiæ, though the nurse religiously sought for them. The temperature curve was about the same as that of typhoid fever.

That there have been cases in this country not diagnosed as such, is probable. If there had been but one case in this family it would probably have been called an irregular form of typhoid or para-typhoid. As it was, but for Dr. Vickery, we should not have given the disease a name. In justice to Dr. Cook, I would say that I did not mention the bird to him. Without that history no one could diagnose the disease.

As far as treatment is concerned, it makes no difference whether the disease is diagnosed or not, as that is purely symptomatic.

Since making this report to the Carroll County Medical Society, Dr. Vickery has made a much better one to the

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Medical News, October 22, 1904. Any one desiring further information can get it by reading that article.

Dr. McConnell, New York.

I do not know anything about it. I do not believe the disease has been taken into consideration very often. I have no doubt but that it has occurred but no diagnosis made.

Volunteer report by Dr. Togus.

Mr. President:

I have a case in mind that I have reported at the District meeting which, perhaps, might interest some of you and bring to your mind the days when the barber used to be the doctor. This case I have in mind now was a man who is n't quite seven feet tall and very narrow, a blacksmith by trade and he lives alone and uses a great deal of alcoholic stimulant. It seems one morning somebody passed by his shop, and seeing nothing moving, they went in and found him lying on a cot, apparently unconscious, quite a pool of blood on the cot. They took him into the house and had a physician from Manchester. He seemed to be bleeding from the nose and was in a semi-comatose condition. They stopped up his nose and still it would bleed. He was in that state for about twenty-four hours; he seemed to be growing worse and still bleeding. On the second day they telephoned me and I did not care to go as I knew the man and I did not want to increase the bill which he was owing me. They sent the selectman down to get me in the afternoon. I told him if they could wait until 7 o'clock, I would go. Said apparently he was bleeding to death and would not be alive at 7 o'clock. I told him I would go, so I went prepared to see if I could stop the bleeding. When I got there he knew enough to recognize me. I felt of his pulse; his pulse was going like a trip-hammer. I commenced to pull the cotton out of his nose and then I rolled up his sleeve and tied a handkerchief

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around his arm and opened one of the veins in the arm, and I took out twenty ounces of blood. When I had drawn possibly ten ounces of blood he seemed to feel better. He commenced to talk. I let it run until he felt a little dizzy and then he got up as well as he ever was and went to work the next day. Here was a man you would n't think needed bleeding, he has been well ever since. He paid me then. He has promised to pay the other bill.

Since then I had a case of a man who had symptoms of pressure of blood on the brain. His temperature was way up and pulse bounding, his face deep red. I had such good luck with the blacksmith I thought I would bleed him also. It gave great relief to this man, but he developed pneumonia the next day, but it ran only about five days, and I believe in his case the bleeding did him good. It is well enough when you have a bounding pulse, and do not know whether it is pneumonia or a shock, to bleed the patient. I think it will benefit the patient.

Dr. Blanchard.

I had an interesting case come under my observation some five or six years ago. A man came to me one evening about 9 o'clock and said, "I have swallowed a part of a set of false teeth; I have swallowed one half of the set and here is the other half." He said he could feel the teeth down near the stomach. I told him that the best thing for him would be to go to one of the hospitals in Boston in the morning. So he went to the Massachusetts General Hospital and Dr. Richardson attempted to remove the teeth. He tried three times on three different days before he extracted them.
By specially prepared instruments he drew them up the esophagus until just above the level of the clavicle, when he cut in and removed them in one piece.

I am reminded by Dr. Day's experience of that of Dr. Wilder, of Whitefield, who reported to our county society the case of a boy aged seventeen, who swallowed a nail one

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and one half inches long, in October. Between that time and the following January he had several severe paroxysms of coughing. On January 2, he developed symptoms of pneumonia. Later it was determined that he had pus in the pleural cavity, and on January 22, the doctor made an excision of a rib in the left axillary line. The pus was very thick and it was thought best to wash out the pleural cavity with a saline solution. During this process the nail came out and dropped upon the floor with considerable cheesy pus adhering to it. Not until then was it known that the nail had been swallowed.

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PRAY PRIZE ESSAY.

THE HOME TREATMENT OF PULMONARY TUBERCULOSIS.

BY HENRI T. FONTAINE, M. D.,

Physician in Charge at the Pembroke Sanatorium for Tuberculosis.

In these days of tuberculosis crusades, the physician might well ask himself whether he is doing his full duty towards his consumptive patients.

The public is wide awake on the subject of tuberculosis. That is, it has become somewhat informed, thoroughly frightened, and naturally turns to the physician for advice.

We of the medical profession seem to be only half awake. That is, we make the diagnosis more or less early and we send our well-to-do patients in search of a climate, or, better still, to a sanatorium; then we feel that we can wash our hands of these until they return as convalescents or in a dying condition. Yet the majority of our cases we always have with us; not only the poor, but also the well-to-do who cannot leave home for business or family reasons. In the care of these lies our chief duty, and a more noble work the profession is never called upon to undertake.

How often do we not put off a far from hopeless case with the simple advice to stay out of doors, or to go to the country, drink all the milk and eggs he can, and be faithful to his medicine bottle. As a rule, the patient complies by eating as

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long as he has an appetite; by taking long walks in the open air, whether he is a fever patient or not, until, tired and exhausted, with quickened pulse and heightened temperature, he has laid the foundation for an acute exacerbation of his trouble. His best chance of recovery has been thrown away. Where does the fault lie? With the patient who has misunderstood his too general instructions, or with the medical adviser who is but half awake; whose advice, though well-intentioned, has been sadly lacking in particulars about the all-important details of daily life? Too often in this malady we make the mistake of attempting to treat the disease rather than the patient.

Before giving the details of home treatment it may be well for us to make an inventory of our usual notions about climate.

CLIMATIC VS. HOME TREATMENT.

No curative principle has yet been found in mere climate, nor yet in altitude, and the promiscuous advice to consumptives to change climate has been productive of little good and of a vast amount of harm.

At first sight this would seem to be a radical departure from our old ways of thinking on the subject of treating tuberculosis. But further elucidation will show that it is not. The principles are the same as they were ten years ago, only we have somewhat confused the essentials with the non-essentials of treatment.

Let us for a moment consider in what consist these essentials, these points on which all authorities are agreed, and which form the cardinal principles of the treatment of tuberculosis.

(1) *Fresh Air.*—Not cold or warm air particularly, not dry or damp air, not rarefied air nor medicated nor modified air, but simply pure, fresh air, as free as possible from dust, gases or impurities; the God-given air which the lungs were made to bring in contact with the blood at every inspiration.

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(2) *Food.*—Not the fancy preparations of albumen, not the vinous solutions of peptones, not the myriads of meat extracts, but the plain, nutritious, easily digestible food to be found in any market.

(3) *Hygiene.*—The removal of the patient from centres of infection; the supervision of his exercise, rest, pleasures, and all mental and physical activities; the prescribing of food, baths and proper clothing; the thorough carrying out of the principles of disinfection; the regulation of all his ordinary habits of life which constitutes a complete change of environment.

(4) *The Symptomatic Treatment* of the frequently supervening complications.

It is a poor section of country indeed in which these four essentials of treatment are not obtainable. It certainly does not apply to our Granite State.

Bearing these in mind, what can we reasonably expect from a change in climate? Change of scene, rest from labor, amusement, rest from the annoyances of the previous environment, a cheerful and optimistic frame of mind.

These so-called advantages of change of climate are in a great measure obtainable at home. Since the patient must give up looking after his business affairs for a long period of time, perhaps years, rest from labor is obtained, and the usual cares and worries attendant upon business life will be thrown off, while his attention is taken up with the details of treatment.

In the few instances where the domestic worries are considerable, the patient had better be removed to the country a few miles from his home, and the visits to and fro be carefully regulated. The complete change in the ordinary habits of life, the regulation of all his actions, the constant attention to the minute details of treatment, will constitute the change of environment, which is so important a factor. The novelty of the situation, the new point of view, will go far towards restoring the cheerful frame of mind we are trying to cultivate.

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Thus far we have not considered the disadvantages of removal to another climate far from home—and they are many.

In the first place is the question of expense. The cost of living is much higher at a health resort than at home, as is also the cost of all the ordinary comforts necessary to proper treatment. To obtain good results the patient should be accompanied by a strong-willed nurse or friend to supervise his treatment, and a competent physician should be frequently consulted. If the pennies must be counted, some of the necessaries of a consumptive's life will surely be foregone, and the patient needs the best of everything. One could live in comparative luxury at home on what would purchase the bare necessities in a health resort.

When far from home surroundings the patient is liable to develop nostalgia, than which no symptom is more fatal to improvement.

There is much misconception about the claim that a milder climate will facilitate the carrying out of the treatment. As a rule the patient who lacks the moral strength to carry out the details of treatment in his home, will never have the courage to put them into practice by himself when sent to a Southern or Western state.

Furthermore, by this removal from home restraint, many a young man has been ruined, being obliged to look to the saloon or club-house for his amusement.

At best, climatic treatment must be reserved for the favored few who have ample means.

Home Treatment.

GENERAL CONSIDERATIONS.

Character of the Disease.—Consumption is not a disease of the lungs merely, but a local expression of a disease which involves the entire system. The lungs are practically beyond the reach of any known remedy.

The object of all treatment is the increase of the physiologic

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power of the patient to resist disease, and destroy or circumscribe its cause within his own body. It is a systematic effort to increase the nutritive forces of the body.

The treatment of tuberculosis is the same whether carried out at home or abroad, in a sanatorium or in an open resort. The conditions of success are dependent on:

First. The character of the patient.

Second. The surroundings or facilities for carrying out the treatment. "Where there 's a will there 's a way," never applied more forcibly than here. Success depends on the relentless attention to details. Of course it is easier in a sanatorium where every one is making efforts in the same direction, but it is only a difference of degree, not of methods.

Third. The treatment is to extend over a long period of time, and the patient should be told so, that he may make a business of it, sacrificing all pleasures to it if necessary.

Fourth. There is required on the part of the physician a comprehensive understanding of the character of the patient, a knowledge of the nature and extent of his lung lesion, and a full appreciation of the importance of even the minute details of his environment.

The home treatment of tuberculosis fails through lack of proper hygienic control, the indulgence of friends and the want of facilities to meet the conditions.

Let us now take up the four cardinal points or essentials of the treatment of consumption as they should be applied in the home of the patient.

OPEN-AIR TREATMENT.

By open-air living we mean being in a centre of constantly changing fresh air. We mean taking in, at every inspiration, air which is not vitiated by having been breathed before. We mean that the patient shall stay in this favorable medium from morning till night, and from night till morning.

It is needless to say that an unenclosed piazza, a camp

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entirely open in front, with opening in its side or back walls, need cause no worry about ventilation. Not so, however, with the glass-enclosed piazza, the ordinary bedroom, or even the commonly-used tent with opening in front only.

Fresh air must be real live air, constantly changing and flowing through the room or tent. Of course your patient will complain of the draughts, but how can you get good ventilation without a draught? Besides, what is dangerous in it? It may be harmful to swelter in an overheated room, and then to let a cold blast chill your body. There may be danger in exposing yourself to a cold wind when the body is covered with perspiration from any cause. But common sense will not allow these things to occur. The patient should avoid chilling as well as freezing. An ordinary draught, in ordinary conditions of open-air living, was never known to do anything but good.

So in order to carry out the open-air treatment, the patient must practically take his belongings and move out of doors.

Here come the difficulties. How are they to entertain their friends? Out of doors, of course, or not at all. As for calling on others, it must be given up, unless the call can be made in the open air. But how can one be comfortable out of doors in winter? By being properly dressed and wrapped, and by artificial heating, if necessary.

A favorite method of keeping warm when sitting out of doors is to spread a horse blanket on the reclining chair, letting it extend well beyond the foot. The patient sits squarely in the chair in the center of the blanket. Now one side of the blanket is turned lengthwise over the body, covering it entirely from the waist down; then the other side is folded over all leaving the patient snugly wrapped, with the blanket projecting over his feet. This projection is turned under by merely raising the feet. Before it is tucked under the feet it may be made to receive a hot soapstone or a hot water bottle when the patient requires it. Thus protected from the cold, one may spend the entire day in the open air, keenly enjoying zero weather.

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When the patient has spacious grounds around his home, it will pay him to construct of pine boards a simple camp or lean-to, entirely open in front, with a back or side opening for free circulation of the air, and to move in furniture enough to enable him to spend his days and nights there in comfort. At one end, a smaller room, entirely inclosed, will serve as a dressing-room and bath-room. As it can be easily heated with a small stove, it will afford all home comforts during cold weather.

A modification of this may be built on a second story balcony, for the more timid patients, or even on the flat roof of a city house, and be much preferable to a tent or a simple awning.

HYGIENIC TREATMENT.

Rest and Exercise.—The patient must expend in other ways no more energy than can safely be spared by the forces required to keep his malady in check, and he must take no liberties with health.

The proper treatment of tubercular foci anywhere in the human body consists in immobilization of the parts as far as possible, until all active symptoms have disappeared. This ought to hold good in lung tuberculosis, but the extreme mobility of the lungs makes it impossible. We should not add to the difficulty by countenancing over-exertion in any form.

Since the lungs participate in all excessive activities, the effect produced is an active congestion in the region of the tubercular focus, and often new tears in old adhesions. It is for this reason that one so often observes, in tubercular subjects, hemoptysis, thoracic pains or the unexpected occurrence of pneumo-thorax after any effort whatsoever.

Fatigue causes abundant organic losses and favors mobilization of the bacilli, whence comes the veritable auto-intoxication evidenced by febrile phenomena.

Forced feeding and life in the open air are of the greatest benefit to a tubercular patient when he is placed under conditions of absolute repose. Here we have another reason for nutritive economy.

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Indiscriminate prescribing of breathing exercise has done much harm. Deep breathing and stretching of the sick lung is not to be done in active cases. Still, careful deep breathing does much good in most early cases where the symptoms are more or less quiescent.

Pulmonary gymnastics and the demands made by them on the lungs to expand beyond their natural limit, as is done in most methods where the air tension is artificially increased, as by breathing out against resistance, are liable to drive the infectious material into hitherto uninvaded areas of the lungs.

A tubercular patient is not helped to resist the disease by a muscular development above his normal standard. Regulate expenditure of bodily energy so that the balance sheet always shows a credit in favor of anabolism over katabolism.

Gentle exercise, like driving or slow walking, will help the patient in many ways, but it must not be done when the pulse is high or the temperature above one hundred degrees.

The best time for this exercise is after breakfast, and again after 4 P. M.

The patient should rest a half-hour before his principal meals. For two hours after his midday meal make him rest in his reclining chair or on his bed. This is the time of day when the temperature usually rises to its maximum.

Prescribe nine hours of sleep at night.

Exercise must be prescribed like morphine, by its effects, and it is, perhaps, the thing most needful of medical direction.

Sleeping Quarters.—The reasons for a southern exposure of the bedroom, camp or piazza on which the patient is to sleep, are many.

In the first place clinical experience has abundantly proven that, other conditions being equal, the patients who sleep in a room which has been exposed all day to the direct rays of the sun improve more quickly than those who sleep in north rooms. And this, irrespective of their spending their days in an equal amount of sunshine out of doors.

Sunlight is, perhaps, our best general disinfectant in tuber-

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culosis, keeping our rooms, bedding, furniture and clothing free from dangerous germs.

Besides, with a southern exposure, one can be easily protected from the strong north and west winds, which should be highly appreciated in cold and stormy weather.

Should a patient not be fortunate enough to have a camp, tent or veranda for sleeping purposes, a room with southern exposure should be chosen. It should be well ventilated, uncarpeted and without curtains or useless ornaments.

The furniture should be simple and only such as is absolutely necessary for the ordinary comforts.

Place the head of the bed against an inside wall so as to avoid the direct draughts from the window.

Small washable rugs are allowable, but should be often cleansed. To clean a room, instead of the ordinary method of dry sweeping, use a mop moistened with one per cent. solution of chlorinated lime, which will at once disinfect and allow no dust to be raised. Remove the dust from furniture with a damp cloth.

Should a little sputum be accidentally dropped on the floor, furniture or clothing, remove the bulk of it with newspaper, which can be burned, then pour a little strong formalin on the infected spot in order to kill the bacilli that may chance to be left. Exposure of the spot to the sun for an hour or so, if possible, will insure thorough disinfection.

Bathing.—The patient should take a good warm tub bath once a week, and follow it by cold sponging. Every morning the patient must take a cold sponge bath, beginning by the application of a little cold water to the neck and chest at first, and later sponging the entire body. This should be followed by a brisk rub with a rough towel to insure proper reaction. As long as the patient reacts, the cold bathing does good. When he does not react properly, it may do harm.

Disinfection.—I usually hand my patients the following printed advice on this subject:

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"A consumptive may in the course of twenty-four hours throw off many millions of tubercle bacilli in his expectoration. Unless properly collected and destroyed these may cause infection in other people, or they may even reinfect the consumptive himself. For example, if the patient expectorates in his handkerchief, the secretion may easily be smeared on his clothes and hands, then deposited on his food. But even if he escapes that, the sputum soon dries on the handkerchief, and when the latter is taken out again the germs will be shaken out and distributed in the air, on the floor, on food, etc., and be taken again into the system of the sick one, reproducing the disease perhaps in some other part. If these germs are deposited on food in large numbers they are liable to set up tuberculosis of the stomach or bowels. There is still greater danger of this happening when the patient swallows his own sputum. So he should guard against it.

"The best way to dispose of sputum is to use a spitcup, which you can buy at any drug-store, and is inexpensive. When the cup is full, throw it in the fire and thus destroy the germs most effectually. When using an ordinary spittoon, have water in it, or, better still, four parts water to one part carbolic acid. This will keep the germs moist until destroyed by the acid.

"When away from home it is well to carry about some Japanese paper napkins in which to expectorate. Throw them in the fire as soon as you return. Never use your pocket handkerchief for this purpose.

"During the act of coughing, drops of sputa or saliva are often expelled, containing tubercle bacilli. To avoid disseminating them, one should hold a handkerchief before the mouth while coughing. On this account it is well to give directions to have a consumptive's handkerchiefs washed separately, or at least thoroughly boiled before putting them in with the general laundry.

"The saliva of consumptives contains the bacilli, so they should not be allowed to fasten the cover of a cigar or cigarette with their saliva. Neither should a consumptive be kissed on the mouth.

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"Knives, forks, spoons, cups and glasses used by a consumptive should be thoroughly boiled after each use.

"Dress comfortably but not so tightly as to impede deep breathing. Ladies should avoid corsets and multiple heavy skirts hanging from the waist. Let your clothing hang from the shoulders as much as possible. Trailing skirts are an abomination, collecting as they do, dirt, sputum, and disease germs of all kinds.

"Tight-fitting shoes are often responsible for cold feet. On rainy days wear rubbers to avoid getting the feet wet.

"Woolen underwear keeps the skin at a more even temperature than cotton."

DIETETIC TREATMENT.

Appetite is not necessary. Food does not have to be adjusted to the appetite, but to the patient, and the appetite ignored.

Give food containing high nutritive quality in the most easily digestible form.

The caloric value of food should be borne in mind. Taking an ordinary example: A tumbler of milk equals two eggs, two ounces of raw meat, sixteen ounces of oysters, one ounce of cocoa, one ounce of cheese or two ounces of bread.

Milk stands at the head of the list, and may be taken hot or cold, but should not be boiled. Eggs come next in order, and may be taken raw, soft-boiled, or cooked in any way except fried. Fried foods of all kinds should be forbidden, as well as pastry.

The albuminoids, carbohydrates and fats must be ingested in a certain definite proportion to derive benefit from them. When one of these groups is given predominance, especially the fats, the weight increases rapidly at first, but it soon becomes stationary and rapidly declines, while there is more or less anorexia.

Experiments have shown that fats are peculiarly well absorbed by consumptives. A suitable diet consists of about one hundred and twenty grams of proteids, one hundred and

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forty grams of fats and three hundred grams of carbohydrates.

Three principal meals a day should be given, consisting of beef, mutton, lamb, chicken and bacon for meats; fresh fish, milk, butter, eggs, vegetables, fruits and light puddings.

Between meals and at bedtime, a lunch of milk or eggs, with crackers or bread and butter, may be prescribed.

Two quarts of milk and four eggs a day are a fair allowance.

Much good may be obtained from the raw beef diet in selected cases. The raw meat is administered as follows: 1. Finely minced or bruised beef, slightly seasoned with salt, etc., according to taste, served cold or gently warmed throughout; one-half pound two or three times daily. The meat must be perfectly fresh. 2. Beef-juice is prepared as follows: Extract one-half pound of meat in one-half pint of cold water plus a half-teaspoonful of salt, heat slow to one hundred degrees F. Express the liquid through a cloth and serve. Or the juice may be expressed from the meat directly without the addition of water. In either case, the beef-juice must be freshly prepared for use. 3. Raw meat soup is prepared as follows: Mix one-half pint of finely-minced fresh meat with sufficient milk to produce a thick, uniform paste. Immediately before serving, add one-half pint of milk at one hundred and fifty degrees F. In place of milk, the soup may be made in similar fashion with stock of beef, chicken or veal.

Never allow a heavy meal when the patient is mentally worried, or physically exhausted.

SYMPTOMATIC TREATMENT.

Cough.—Cough should not receive much treatment, as the remedies usually employed are liable to disorder the digestive functions. As the patient's general strength increases and the lesions in the lung heal, the cough gradually disappears.

The patient should be told to control mentally an habitual dry cough. To abort a paroxysm of cough, take several long and deep inspirations, followed by forcible expiration. An occasional sip of cold water, chloroform water, lemonade or orange juice will help overcome it.

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For the morning cough give a glass of hot water with lemon juice, or a glass of hot milk before the patient gets out of bed. For the distressing night cough that prevents sleep, heroin and codein are our best remedies. Steam inhalations, alone or with tincture benzoin or creosote, will do much to relieve a cough with scanty expectoration. Counter irritants often do good.

When it arises reflexly from inflammation of the pharynx, larynx or trachea, local treatment is indicated.

Hemoptysis.—When the bleeding is scanty, and due merely to capillary oozing, all that is required is rest in the recumbent posture, with one-sixth grain of codein and a glass of milk given every two hours.

When the bleeding is more profuse, complete rest in bed, with liquid diet, free catharsis, and nitroglycerine or amyl-nitrite, to lower the blood pressure, are indicated. The first thing to do is to relieve the anxiety of the patient by means of one-fourth grain of morphia given hypodermically.

Catharsis is especially indicated when the bleeding is due to congestion of the alimentary canal.

The occasional hemoptysis caused by too low a tension of the blood is effectually stopped by administering digitalis.

In hemorrhage of a gushing nature, due to the erosion of a large blood vessel, in addition to morphia and amyl-nitrite or nitroglycerine, it may be necessary to stop the venous return of blood from the extremities. This is done by applying compression bands about the limbs at their junction with the body.

Every effort must be made to help the production of a firm blood clot at the bleeding point. When the patient has lost so much blood that the blood pressure is reduced almost to zero, the condition is conducive to the formation of a firm clot.

There is a natural tendency to the spontaneous chècking of a hemorrhage, so our treatment should be tentative, rather than over-active.

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A great many remedies have been used for this one complication, and occasionally it is necessary to resort to some one or other of them, so a short discussion on their merits will not be amiss.

We have said that the indication was to favor clotting at the bleeding points; and those remedies must be employed which will lower the blood pressure in the pulmonary artery. Hence the use of nitroglycerine and the nitrites.

Ergot and atropin, though often used, are contra-indicated, because they both produce a distinct rise in blood pressure in the pulmonary artery.

Injections of normal salt solution will also do harm by increasing the blood pressure, and by washing out the clot already formed.

Gelatine is of great value in increasing the coagubility of the blood. The dose should be at least one-half ounce of the dry gelatine. It may be dissolved in warm water, but should not be cooked, as cooking converts it into a different substance.

The spontaneous effort of nature, however, must not be overlooked.

GASTRO-INTESTINAL SYMPTOMS: *Constipation.*—Increase the amount of fruit and green vegetables in the diet; also the amount of fluids and fats. Massage of the abdomen, practiced by the patient before getting out of bed, may afford relief. A. S. B. pills with Cascara Sagrada are good routine remedies.

Diarrhea.—Careful regulation of the diet will do as much as anything to control this symptom.

When the diarrhea is acute, cleanse the intestinal canal with castor oil, and give appropriate food, like cocoa, toast, eggs, rice, mucilaginous soups, scraped meat, mutton broth, etc.

The idiosyncrasies of the patient should be carefully studied. Occasionally one is found who does not digest raw milk. The curds are found in the stools. The simple addi-

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tion of lime water or boiling water to the milk, often relieves this condition, so does the change to boiled milk, or cocoa made with milk. Another may not digest raw eggs, but have no trouble with them if soft boiled.

When the diarrhea is persistent, a change to a liquid or semi-solid diet for a while may be sufficient.

In severe cases give Epsom salts, ten to fifteen grains, every half-hour, or bismuth in large doses.

When diarrhea is due to ulcerations, bismuth and opium, or tannic acid combined with iodoform are useful.

Hot claret with cinnamon will afford temporary relief.

A warm flannel abdominal bandage should be constantly worn.

Anorexia.—The bitter tonics are useful in these cases. A mixture of nux vomica, gentian, columbo and cinchona will act better than any single drug.

Some patients will eat in the open air who cannot do so in a dining-room. Aversion to warm meats is remedied by giving cold meats.

Fever.—When the temperature is above 101 degrees the patient should have complete rest in bed until it is reduced. Put him on a liquid diet, preferably milk every two hours.

The use of the antipyretic drugs is of doubtful value. However, phenacetin and antipyrine are occasionally used.

Night Sweats.—Sponge the patient with cold water or alcohol, once or twice every twenty-four hours, which helps to restore vasomotor tonicity. Sponging with water and vinegar at night, or with formalin and alcohol, equal parts, will often have the desired effect. The wet pack is also useful. Give night lunches when the patient is hungry. The drugs most in use for this symptom are atropine, grain $\frac{1}{100}$-$\frac{1}{60}$; agaricine pill, grain $\frac{1}{12}$ to grain 1; Camphoric acid, zinc oxide, grains 2–3, may all be tried.

Chest Pains.—When due to pleurisy, limitation of the chest movements on that side by strapping will give relief

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and promote healing by keeping the parts more at rest. In acute pleurisies, cupping, blistering or the use of the thermo-cautery will relieve pain. For pain due to myalgia, massage the muscles gently once a day. For neuralgia, when severe, use warm applications.

MENTAL OR PSYCHICAL TREATMENT.

The mental attitude of the patient is an important factor. Depression calls for optimistic encouragement, sanguine disposition, and coercing restraint.

Tuberculous patients are largely susceptible to suggestion, and by it you can easily increase the action of any remedy you may see fit to use.

The sooner you establish a bond of sympathy, confidence and control between yourself and your patient, the easier will the treatment become. Meet frivolity with sternness, ignorance by benevolent instruction; foolish conduct by firmness and constancy.

The protracted course of the disease taxes the endurance of the most strong-willed patient, and requires the sustaining guidance of frequent medical advice to overcome the hardships, trials, temptations and discouragements which are in the path of recovery.

The patient should be guarded against emotions and moral impressions liable to raise the temperature by suggestion.

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ADDRESS

TO THE GRADUATING CLASS OF THE MEDICAL DEPARTMENT OF DARTMOUTH COLLEGE, MARCH 31, 1906.

BY IRA J. PROUTY, M. D., KEENE.

Mr. President, Gentlemen of the Faculty, Members of the Graduating Class, Ladies and Gentlemen:

To some before me the frost of custom has made these annual ceremonies cold and lifeless, but to you of the class of 1906, it is an important milestone upon life's journey. This day comes but once to mortal man. The hard tasks of preparation are over and the earnest work of life is at hand for you. Equipped as you are with the weapons of science, you go forth, doubting not, fearing not,

"But with purpose firm and true,"

and take your place in the ranks of the world's workers, who shall bless mankind by their labors.

The college you are leaving has a venerable history of more than a century and has done her part well in advancing the cause of higher medical education, and to-day, we are all proud of Dartmouth's success, whether we are alumni or not.

When the first delegates from the New Hampshire Medical Society came here by stage-coach more than eighty years ago, what a patient said and what the doctor saw and felt, were all that a case had to tell him. You can not now realize the extent of such limitations, because instruments and methods of precision have so interpreted what we merely see, feel and

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hear, that even if we were again forced to rely upon our unaided senses, we should stand upon a higher level than our medical fathers. The restrictions from which they suffered, drove them into attempts to classify, and multiply minutely the signs of disease, until what they thought they found represented impossible refinements in symptomatology.

We, to-day, use as many instruments as a mechanic, nevertheless, however much we may gain thereby, our machines are not labor-saving.

They force us, by the time their uses exact, to learn to be accurate as well as rapid. If you will think over the number of instruments of precision a given case may require, you will clearly see that no matter how expert one may be, the diagnostic study of an obscure disease must to-day exact an amount of time far beyond that which Sydenham, Nathan Smith or Dixi Crosby found need to employ.

A post-mortem section used to take an hour or two, and now, alas! it goes on for weeks in some shape or other until the last staining is complete, the last section studied, the last analysis made. These increasing demands upon us are due to the use of instruments of precision and the use of accurately precise methods. As in our factories more and more exact machines have trained to like exactness a generation of workmen, so with us physicians, the use of instrumental aids, rendering the comparison of individual labor possible, has tended to lift the general level of acuteness of observation.

"The instrument trains the man; it exacts accuracy and teaches care; it creates a wholesome appetite for precision, which at last becomes habitual." The microscope, the balance, the thermometer, the chronograph, have given birth to new standards in observation by which we live, scarcely conscious of the change a generation has wrought.

The world at large has learned to be precise by the use of instruments, an example of which is the lesson taught by the railway and made possible by the watch.

Let us go back for a little time to the birth of the two first instruments of precision. Their history has not been re-

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corded in any one biography of their discoverer, Galileo, but has been gathered here and there in memoirs, journals, lay-biographies, rare and old folios and forgotten essays.*

During the first part of the sixteenth century, there came about a tremendous change in habits and methods of thought, and the acquirement of knowledge. In general literature this period is known as that of the Renaissance. It was truly an awakening in every department of knowledge and along every line of study. It was as if the minds of men had been dormant and lost their power of receptivity,

"As a vast eclipse, the human mind o'erspread,
And learning slumbered as the mighty dead,"

but awakened in a new atmosphere and amid new surroundings.

The latter half of the sixteenth and the first part of the following century was a germinal period in medicine. It witnessed advances in anatomy and physiology which led up to Harvey's splendid discovery of the circulation of the blood. It saw, too, the failure of his thesis to influence medical thought in any way. These same years witnessed in Italy the first attempts at precision as regards temperature and study of the pulse.

This was the birth of instrumental accuracy in medicine, but many a day went by before the infant attained a useful manhood. It seems strange that the seeds of scientific thought as to the first heat records and the pendulum were cultivated in the garden of medicine.

The early history of the first thermometer and the pendulum, like that of the telescope and the microscope and many other pieces of philosophical apparatus, has until recent years been considered very obscure, as there were various claimants who sought to share at least a part of the credit of the discoveries.

Science has never grown in an even fashion. When in watching a saline solution under the lens, you observe some

*Many of the facts concerning Galileo have been taken from the writings of Dr. S. Weir Mitchell and no further credit will be given.

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brilliant crystal shoot out in advance and hold its place until the rest more slowly but surely join or pass it, you can see an image of that which illustrates our discoverer. There are few men of science whose lives offer so much of picturesqueness and interest to the mind as that of Galileo. Marvelous genius though he was, he lived and did his great works among the people, sharing with them in all the vicissitudes of public and private life. He brought plain common sense into everyday matters. As a boy he had a keen taste for music and was also endowed with considerable artistic power, which he cultivated diligently, and thought he would follow painting as a profession. His parents were poor and hence his father decided that he should study medicine as a means to earn a livelihood.

At the age of seventeen he was duly enrolled as a student at the university of his native city, Pisa. Here he obtained some inkling of mathematics and was so much interested that he begged to be allowed to study geometry. He continued his mathematics until he came to the famous forty-seventh proposition, which won his lively admiration, and on he went until he had mastered the six books of Euclid which was a considerable achievement for those days. His teachers regarded him as a somewhat misguided youth, as young Galileo had the audacity to think for himself concerning the laws of nature. He would not take any assertion of fact on the authority of Aristotle, who was regarded as the embodiment of all human wisdom in natural science, as well as in everything else, when he had the means of questioning nature directly as to its truth or falsehood.

It is not known exactly the date that Galileo invented the thermometer, but from his letters, written years afterwards, we find that it was somewhere between the years 1593 and 1597. It was simply a tube of glass open below and ending above in a bulb. The bulb being warmed, the open end was set in water, so that as the bulb cooled the water rose in the tube, and then any heat applied to the bulb would lower the water, which was the reverse of what happens in our thermometer of

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to-day. Of course we can see that it was not accurate, nor was it thought much of by its inventor, for it is not mentioned in his works. It is from his letters that we know of it, and from letters that he received from others, who improved it and gave him the credit of its invention. A Venetian noble, Giovanni Francesco Sagredo, writes to Galileo in 1613, that "the instruments that you invented I have bettered." He made one hundred divisions on the scale and two years later, in 1615, hermetically sealed the tube, thus giving us the modern instrument. It was years before physicians used this improved form, still clinging to the rude invention of Galileo.

There were many who claimed for themselves the invention. This was not strange. From the days of Elizabeth, every man of fashion, especially the English, travelled in Italy. Here, too, wandered all who were interested in science, or who studied, and it was to Padua that Bacon came and also the greater Harvey. The towns of Italy were the exchange of all Europe, for both commerce and science. Men took home what facts they saw or heard, and merely describing them, as Bacon did the air thermometer, left the future critic to discover who was the one entitled to the priority of the invention. The temper of the times was different from the days in which we live. Men worked patiently along. There were no journals, the letter or the lecture were the only means of early publication of any discovery or invention. The genius of to-day, who invents a new instrument, yearns for instant type and defends his offspring with great virulence. Harvey knew his great discovery of the circulation of the blood in 1616; he was certain of it, and clearly knew what he had done. Supposing some wandering Italian, hearing his lecture, had gone home and stated in a book the facts of the circulation, there would have been, even to this day, a great deal of controversy.

One of those who wrote about the thermometer, not claiming as his own, but not mentioning Galileo, was a fellow student, Santorius Santorini, who was educated at Pisa and at Venice. In his commentary on Galen, published in

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1612, he says: "We have here an instrument with which we may closely measure the recession of the heat of the external parts, and with which we may daily learn with accuracy how much we may vary from the normal, also the degree of heat of your patients." He further adds, "The patient grasps the bulb or breathes upon it in a hood, or takes the bulb into his mouth, so that we can then tell if the patient be better or worse, so that we cannot be led astray." He gives no table of temperatures, no records, and hence no good comes of it. The enthusiasm of the writer kept the instrument before the public for some years. Nevertheless, Santorini saw what might be the value of the thermometer in medicine. He first taught the lesson of using the mouth in obtaining a record of bodily heat, and may certainly be given the credit for improvements in the methods of its use. The thermometer lacked precision, even when it had grown into this. Want of knowledge of the cause of fevers, of their risk and how to lessen them, caused the great mass of physicians to neglect an instrument, which, as yet, had for them little practical value. Here and there as time goes on, in physiologies, and soon in the works on practice, we find rare statements as to the heat of man.

Another astronomer we have to thank, when in 1701 Newton marks the temperature of the blood at twelve degrees of his scale and uses linseed oil as the fluid. A little later Daniel Fahrenheit altered the scale over and over and finally set ninety-six degrees as the heat of the blood, and he used the thermometer in the axilla, this being the first time that we have a record of armpit temperature. Boerhaave claims the use of mercury, but it is not proved certain by the records of the famous Paduan Academy, that long before it was made use of by the Italians.

We have seen the beginning of the practical use of the thermometer, which very soon became accurate enough, and how for several centuries it fell into disuse while medicine awaited the more correct theories of heat.

Let us turn now to a no less wonderful story of the early

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application of instrumental accuracy to the study of the pulse.

We have seen that it was an astronomer who gave us the first crude thermometer, and it was another, Kepler, who first, and before the commencement of the seventeeth century, counted the human pulse, or at least left a record of having done this memorable thing. The publication of these records date from 1604 to 1618. Can you imagine that of the numberless physicians, that sat by bedsides with finger on the bounding artery, none were thoughtful enough to have counted the beats? Herman Kepler had a fanciful imagination, and believed the pulse to have had some relation to the motions of the planets, and used the beats of the pulse in connection with his arguments in favor of the Copernican system of astronomy. He says in his "Opera Minora," published in 1618: "In a healthy man, robust and full of age, generally for each second there is a pulsation of the artery with no discrimination between systole and diastole: thus there should be in one minute sixty pulsations, but this is rare slowness, commonly being between seventy, and in the full-blooded and in women eighty, four to each three seconds."

The other discovery made by our tireless astronomer, Galileo, marks a pregnant hour in scientific history.

There is no more lovely, softly melancholy picture in all Italian scenery than the group of buildings, the cathedral, the baptistry and the leaning tower, standing apart as they do from all others in his native city, as I saw them on a sunny afternoon. The Basilica, of white and black marble, dates from the tenth century. It is of magnificent proportions, and was erected to commemorate the victory of the Pisans near Palermo. From the ceiling of the nave hangs a huge bronze lamp that has four burners. It hangs by a long-linked chain sixty-five feet in length. In Galileo's younger days he spent much time within this beautiful structure, enjoying the peaceful quiet, and maybe to get away from his mother, who, history says, had a most violent temper.

He discovered that this great bronze lamp vibrated, and

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sighting, with the pillars that supported the huge canopy over the high altar, found that it swung as far out one side of the centre as the other, and that these vibrations corresponded very nearly with the beat of his own pulse. He immediately went out and began his experiments. Everything was favorable, more so than probably could be found anywhere else in the world. Within a few feet of the cathedral is the celebrated Leaning Tower, begun about the time of the commencement of the cathedral, but not completed for more than two centuries afterwards. It is not known for a certainty, but is generally supposed, that the foundation on the south side settled so that at its top, a distance of one hundred and seventy-nine feet from the ground, it projects thirteen and one-half feet over its base. The upper stories were built in nearly a perpendicular line, so they tend to correct the unequal weight. In the top are seven bells, the largest one being placed near the north edge, and weighing six tons, goes far towards restoring the equilibrium of this one-sided structure.

Galileo ascended from one story to another and swung his pendulum, noting the length and vibrations, counting them by his pulse. Forty years later, in describing his first clockwork, he says with enthusiasm, "My clock will not vary so much as the beat of a pulse."

Vivian, his biographer, says, "The unerring regularity of the swing of the huge lamp, suggested to the young medical student the reversed idea of marking with his pendulum the rate and variation of the pulse. Such an instrument he constructed after a long series of experiments. Though imperfect, it was hailed with delight by the physicians of the day, and was soon taken into general use. It was called by its inventor "the pulsilogon." There was the pendulum having a bullet for the weight, having a white line painted upon it. He made a scale with no arbitrary markings. He swung the pendulum and noted the pulse with the finger. If the pulse was faster than the pendulum, then he would shorten it until they coincided. "Then," he says, "we keep this in

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mind until the next day and compare it with a new record. Thus we can study the pulse of health and disease." He also measured the time one must need to breathe on the thermometer. Santorini, of whom we have spoken before, taught in his lectures on the practice of medicine, at Padua, the use of the thermometer and the pulsilogon, but with his death, in 1636, the instrumental study of the pulse ceases for many years.

In all the vigorous sketches of disease which the great Englishman, Sydenham, drew with a master's hand, there is not a pulse count, and only once does Harvey speak of their number, which he says is from one thousand to four thousand in the half-hour.

In 1707, Sir John Floyer wrote a notable book called "The Physician's Pulse Watch." This watch only ran sixty seconds. As late as the middle of the eighteenth century we can only find an occasional mention of counting the pulse, as where Morgagni describes a pulse which beats twenty-two times in the sixtieth of an hour. Evidently the minute had not got into the daily life of man, for it is not till the latter part of the first quarter of the nineteenth century that the doctor with watch in hand came to be commonplace.

With his thermometer and the pulsilogon, and with this picture of testing the accuracy of the swing of the lamp by his own pulse, this marvelous mind passes out of medical history. Where he would have left it if he had remained with us none can say. Of his loss a poet has spoken:

> "Ah! when in Pisa's dome
> He watched the lamp swing constant in its arc,
> He gave to man another punctual slave,
> And bade it time for us the throbbing pulse.
> Not that grave Harvey, whom Fabricius taught,
> Not sad Servetus, nor that daring soul,
> Our brave Vesalius, e'er had matched his power
> To read the riddles of this mortal frame.
> And then he left us. Would our strange machine
> Had kept his toil, and cheated Heaven's fair stars."

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Gentlemen of the Class of 1906:

Your college days are past, and to-night you join a great and noble profession whose value to the community is beyond estimate, and which, if you do your part well, guarantees to each one of you a happy, contented and useful life. You have labored hard during the years of preparation, and you will labor much harder in the years to come, if you are in earnest about your work. Emerson says that "in nature nothing is ever given away, everything is bought." For some things we pay dollars, for others time, and for others hard labor. Time and hard labor are the sure and only currency in the realm of medicine, for these alone will bring to you success.

Success is only a relative term, related to our sphere in life, and our opportunities. There is a dignity in mediocrity as well as of greatness.

The humble country doctor—like Scott's "Gideon Gray"—if he has kept abreast of the times by after study, and has made the most of himself and his opportunities, has achieved true success. If it is your lot to practice in the country, do not shelter yourself as has often been done, behind the excuse of incessant work and endless drives.

One of the most remarkable medical pictures of the time is that given by Dr. John Brown, of Dr. Adams, of Branchovy, a country doctor, in a secluded Scotch village. With constant hard work on horseback, amid bleak hills and valleys for miles around, without ever neglecting his work, became the most accomplished linguist of his day. And at breakfast was fond of amusing himself by translating an ode of Horace into Greek verse.

Osler says "there are two kinds of doctors, those who practice with their brains and those who practice with their tongues." The studious, hardworking man who wishes to know his profession thoroughly, who strives to obtain a wide and philosophical conception of disease and its processes, often has a hard struggle, and it may take years of waiting before he becomes successful, but remember that these men

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become the bulwarks of our profession and outweigh scores of the voluble chaps who talk themselves into, and often out of practice. For the soldier of medical science there is no blaze of trumpets, no beating of drums, no shouts of the combatants, no public honors, no laurel wreaths. He will live in grateful hearts, unknown in the pages of history, or even beyond a small circle of friends.

"They have no place in storied page,
No rest in marble shrine:
They are past and gone with a vanished age,
They died and made no sign.
But work that shall find its wages yet
And deeds that their God did not forget,
Done for their love Divine—
These were the mourners, and these shall be
The crowns of their immortality."

There are two things that the public demands of a doctor, honesty and intelligence, without either one you will not succeed. You must be honest with those who put themselves under your charge, never mind whether they come from a hovel or a mansion.

Try to make every patient your friend. Your first patient should be your friend, if possible all through your life, for you should not forget that he is the first of the world's inhabitants who is willing to trust you and pay you for taking up the fight against disease and death. You must be honest with your fellow physicians, and let me say to you right here, that every word spoken in detriment will come back to you with compound interest. And last of all you must be honest with yourselves and remember always Lowell's definition of a gentleman. "A man of culture, a man of intellectual resources, a man of public spirit, a man of refinement, with that good taste which is the conscience of the mind, and that conscience which is the good taste of the soul."

The public demands of the physician, intelligence, and demands a higher degree of knowledge each year. You may

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have thought that with to-day your student days were over, but if you are to achieve success you must always be a student and ever ready to grasp opportunities, and must "keep step to the music that you hear," or else you will be a laggard in the procession.

A clergyman may have to reverse his opinion because the bishop decided so and so. A lawyer may give a client advice and find that in the "reports" there has been a ruling that is the opposite, or if the case has gone to the jury, the judge is very likely in his charge to the "twelve men good and true," to make a similar statement. Thus, no matter how wise his beliefs, how patent his facts, he must abide altogether by what some one else has said who is of higher authority than he. You will be counsel, judge and jury, all in one. You will have no creed, but experience, common sense and humanity, combined with what medical science has taught you. The fact that some other doctor has done thus or so regarding a disease or operation need have no fear, and in no way restrain you. If you discover anything better and can prove it, your professional brothers will be ever ready to join hands and voice with you in letting the world know what you have done.

Commence your professional life by keeping a record of your cases, and there is no better way than by the card index. If you cultivate this habit from the start you will never regret it. Study each of your cases, especially the earlier ones carefully.

Receive all the help possible from the scientific use of the instruments of precision that are at our command, but remember that the man behind the microscope can not sit in his laboratory and tick off diagnoses for you by the yard. You must do some of the thinking at the bedside and in your study.

Begin at once to lay the foundation for a library. For the first few years you may have to give up some luxury or amusement in order to do so, but in after years you will never regret it. The old saying is "Beware of the man of one book."

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It has been surprising to me how much work such a man would do, and how poorly he would do it. I would advise you at once to subsbribe for a good medical journal, and I know of none better than the Journal of the American Medical Association, as this is our National Society, and then add others to your list as you can do so. A doctor without a journal is like the business man without a newspaper. If you neglect your books and your journals you will be left high and dry on the beach. The medical journal stands in the same relation to your library as does the newspaper to works of history. It is in utilizing the fresh knowledge of the weekly journal that the young physician may attain to the name and fame that he deserves.

"Great theologians, like Calvin or Jonathan Edwards, were they recalled to life, could discourse as learnedly as ever on predestination and free-will; great preachers, like a Beecher or a Spurgeon, could stir our souls and warm our hearts as of old; great jurists, like a Justinian or a Marshall, could expound the same principles of law, which hold good for all time; great forensic orators, like a Burke or a Webster, could convince us by the same arguments and arouse us by the same invectives or the same eloquence as made our ancestors willing captives to their silvery tongues. But, to-day, so rapid has been the progress in our science that if Crosby, Bigelow, Parker or Pancoast, all of whom have died in the past forty years, were with us again, neither of them could teach modern surgical principles or perform a single modern operation."

Epictetus asks, "Do you expect that the greatest of arts is to be acquired by slight endeavors?"

As I have said, you must be students always if you are to win success in your professional career. I want to impress upon you, as Osler has often done to students before, that the master word in medicine is *work*.

It is a little word, but one fraught with momentus consequences if you can but write it on the tablets of your hearts and bind it upon your foreheads. Laying hold upon it, Hippocrates made observation and science the warp and woof of

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our art. Galen so read its meaning that fifteen centuries stopped thinking and slept. We have seen that Galileo by its inspiration gave us our two first instruments of precision, and in later years with the same inspiration, he overthrew the Ptolemaic system and established the planetary. He found that the moon was another earth, the earth another planet, and all were subject to the same laws.

Students of Medicine: May this day be to each of you as it was to me when I entered the profession, the beginning of a happy life in a happy calling. I trust that each one of you will be "glad of life because it gives you the chance to love and to work and to play and to look up at the stars, to be satisfied with your possessions but not content with yourself until you have made the best of them, to despise nothing in the world except falsehood and meanness, and to fear nothing except cowardice; to covet nothing that is your neighbor's except his kindness of heart and gentleness of manners; to think seldom of your enemies, often of your friends, and every day of Christ."

I welcome you, into the large and goodly company of workers and soldiers of knowledge who are earnestly engaged in the campaign against ignorance and disease. Be an honor to old Dartmouth, true to your fellowmen and to God throughout your lives, and his gracious benediction will be your final reward.

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REPORTS.

REPORT OF DELEGATE TO THE INTERNATIONAL CONGRESS OF MEDICINE.

BY JANE ELIZABETH HOYT, M. D., CONCORD.

The fifteenth International Congress of Medicine was opened at Lisbon, April 19, with King Carlos in the chair, literally in the chair, for he sat and read his address of welcome. (To the Queen at his right belonged the honorary chair.)

His speech was listened to with eager attention and was followed by hearty applause. The king and queen rose in response to the demonstration. The President of the International Congress, Prof. Costa Alemas, then read an address, but it could not be heard. The people, after having struggled in vain to hear, for the most part passed the time in conversation. The Secretary, General Bombada, in name of the committee, appointed the honorary presidents of Congress. Government delegates from the various countries in turn responded to the roll-call, some in their own language, others in French, irrespective of their nationality. Some spoke both in their own language and in French. France, Germany and Austria were among the first on the roll-call. Professor Waldeyer, of Berlin, responded in German for his country. The Austrian representative from Vienna preferred to address the Congress in French, rather than in his mother tongue, German. Major Richards of our army, in place of General Wise, bore greetings from the U. S. A. His

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speech was short and to the point, given in English. Sir Dyce Duckworth spoke in "Queen's English" for Great Britain, saying that he brought greetings from the king, from the men of the profession in his kingdom and from the women as well.

Santini spoke in a clear voice his own rich language, despite the fact that the languages of the International Congresses are limited to French, English and German. He brought heartfelt greetings from Italy and spoke appreciatively of the king and the queen, complimenting the latter most gracefully.

During the next six days interesting papers were given in the various sections of Congress. Dr. Sauerbruch, a German, for instance, exhibited a pneumatic box in which operations on the chest cavity can be performed without a collapse of the lung tissue. Dr. Chase, of Boston, exhibited cimetograph representations of convulsions and walks in different forms of paralysis. The pictures were good and indicated patience and persistency to have secured them.

Dr. Agnes Vietor, of Boston, gave a paper on general splanchnopthosis, the result of fourteen years' research. It showed original thought and if her ideas are adopted they will revolutionize methods of dress for both man and woman.

Dr. Lucia Waite, of Chicago, gave a paper, the result of seven years' research. Her subject was "No Definite Normal Uterine Axis." She asserted that there is no definite normal position of the uterus if free, that it may lie in any position in an otherwise normal pelvis without producing symptoms. A normal uterus must be mobile and fixation of the uterus is only replacing one pathological condition for another. She has demonstrated to her own satisfaction that there are no classical symptoms of antiposition or of retroposition and that they cannot be diagnosed by symptoms.

So far as the sights of the city were concerned, Lisbon literally belonged to the members of Congress. By the simple presentation of the membership ticket anything in the city that was worth seeing could be visited. All the hospitals, clinics, asylums, both municipal and naval disinfecting sta-

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tions, milk station and all museums and collections were open for inspection.

The new building of the *Ecolé de Medicine* was practically christened by this holding of Congress. Lisbon has one entirely new hospital and several new public dispensaries, a new naval disinfecting station, supplied with the apparatus for three methods of disinfection—the dry, the moist, and the moist under pressure. A new milk station, under the supervision of the philanthropic women of Lisbon for the benefit of poor women and their babies, is a credit to Portugal, and the same would be to any country.

There seems to be a general wide-spread interest in better provision for the needy and defective classes in Portugal. The queen's sympathy seems to be strong in this direction, so much so that an honorary degree of medicine has been accorded her. The Portuguese from every station in life showed himself glad to go out of his way if he could but be of service to one of Lisbon's medical guests. The Portuguese professional men and women both outdid themselves in politeness. As for fêtes and entertainments, beginning with a reception and ending with a reception, there was seemingly no end. Three grand receptions were given, one by the Geographical Society, in whose hall Congress was opened; a second by the minister of the Interior, and a third by the city. At the last named, champagne flowed as freely as water even though Lisbon counts herself poor.

A grand bull fight was given in honor of Congress and cost the donors thirty thousand dollars. It was accompanied by ancient Portuguese equestrian games which displayed magnificent horsemanship. The performers were amateurs, knights of high birth who gave themselves freely for the pleasure of the medical visitors who were representing all nations. The horses were beautiful creatures and their trappings were festive and becoming. Their riders, in antique Spanish costumes of velvet and gold, together with the picador's fancy dress, completed a picturesque scene. The bulls were also handsome beasts and acted quite as if they were used to the game. There were six at different times in the

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ring and the last two surprised the people and the players too, by leaping the barrier which surrounds the enclosure. The last bull did it four times, to the consternation of those sitting in the front row of the ampitheatre. The bulls' horns are protected, for the horses are too valuable creatures to be injured. All bull fights in Portugal are bloodless, the law prohibits the cruelty which Spain allows. The king, the queen, the queen mother (Maria Pia), and the king's brother (the Duke of Oporto) honored the occasion by their presence in the royal box. The naval parade up the river Tagus to Villa Franca, where the bull fight was given, was a handsome spectacle. The whole village was in gala attire. Every balcony was hung with drapery, and flags were flying all along the line of march from the pier to the arena (or torro). The road from the pier to the main street was strewn with palm strips and roses.

"The Congressistes" were also given two garden parties, the first was by the Viconte Mont Serrat, at Cintra. The second was by the king and queen, in the garden of their city palace. To the American who had the privilege of attending, there was no more enjoyable occasion than the dinner given by the American minister, Mr. Bryan, of Chicago.

Taking it all in all, this Congress was an enjoyable and satisfactory one.

REPORT OF DELEGATE TO THE VERMONT STATE MEDICAL SOCIETY.

BY OLIVER D. EASTMAN, M. D., WOODSVILLE.

October 12 and 13, 1905, I attended the ninety-second annual meeting of the Vermont State Medical Society at the new medical college building, Burlington, Vermont.

Dr. P. E. McSweeney, of Burlington, Vt., *President.*

Dr. M. L. Chandler, Barre, Vt., *Vice-President.*

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Dr. George H. Gorham, of Bellows Falls, Vt., Secretary, showed membership of the Society to be about four hundred, the same as last year.

Dr. M. H. Eddy reported eight deaths during the last year, of which obituaries of these members were later presented.

Considerable amusing comment was manifest over the medical registration act. Dr. Gorham reported that the committee on legislation in conjunction with similar committees from the homeopathic and eclectic societies secured the passage by the last session of the legislature of the medical registration act, which provided for the examination and licensing of all physicians by a state board of registration. It consists of three allopathic, two homeopathic, and two eclectic physicians. Consequently, the board of censors of the different societies has been abolished. I was informed that only a very few physicians of the state were registered and all who were not would be obliged to go before the state board of registration and be examined by the payment of fifteen dollars.

Many very interesting papers were presented. Dr. P. E. McSweeney, President, gave the annual address, subject, "Tumors Complicating Pregnancy." The address was a well considered one and his wide experience gave him an exceptional equipment for the discussion of the question. Many other papers were very interesting and would do honor to any society.

One of the charming social features of the gathering of the Medical Society was the reception tendered by the ladies in the afternoon, from two to five o'clock, at the Ethan Allen club rooms. The affair was largely attended. The rooms were artistically decorated with palms and cut flowers. Music for the occasion was furnished. The guests were received with honor. Refreshments were served.

To Hon. Redfield Proctor, who recently presented to the people of Vermont the munificent gift of one hundred and fifty thousand dollars, for the establishment of a sanitarium for incipient tuberculosis patients, the convention passed a resolution of thanks.

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The evening banquet was attended by one hundred and twenty-five guests at the Van Ness House, it was a pleasant affair and greatly enjoyed. Dr. W. S. Nay acted as anniversary chairman. Toasts were given the Vermont Medical Society, its past, its present, all presented in a very graceful manner. The speaking was not finished until 1.15 A. M.

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POST-PRANDIAL EXERCISES.

FOREST L. KEAY, M. D., CHAIRMAN.

Fellows and Guests of the New Hampshire Medical Society:

Owing to the lateness of the hour and that one of our speakers has to take the train north, we will begin the exercises now. I highly appreciate the honor you have conferred upon me by having chosen me to preside over these exercises. The first sentiment of the evening will be responded to by our worthy Vice-President, and it gives me great pleasure to introduce to you Dr. Ira J. Prouty, of Keene.

IRA J. PROUTY, M. D.

NEW HAMPSHIRE MEDICAL SOCIETY.

Mr. Toastmaster, Fellows, Ladies and Gentlemen:

I am sure that we are all sorry not to have our esteemed President, Dr. Stillings, with us to-night to respond to the sentiment of the New Hampshire Medical Society. The doctor did not feel able to be present even in an official capacity, and I am sure all the Fellows of the Medical Society have great sympathy with Dr. Stillings in the bereavement which has come to his home since the last meeting.

As I stand here, responding to this toast, my mind goes back to one year ago, when our late friend, Dr. Felt, occupied the same position. If you remember, he went out as quickly as he finished speaking. I followed him and assisted

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him to bed. As he was getting into bed he said, "I had no business to go there, but I wanted to see the fellows once more. Never shall I see them again." A few weeks after that I was called to Hillsborough to see Dr. Felt, which was the last time I saw him before his mind became clouded, and he looked up and said, "I am glad I went to that meeting."

The meeting this year marks a new era, it seems to me, in the history of the New Hampshire Medical Society. It is the first year of the new régime of an organized profession. I think all the states have come into line and are all working in harmony as branches of the American Medical Association, which will hold its annual meeting in Boston the first week in June. I am sure that none of you will regret the time spent if you attend. The character of the papers to-day has been marked, but there is one thing that I wish to call your attention to, and that is the absence of discussion. We derive more benefit from the discussion of our papers than from the papers themselves. To-day, as I have listened to the papers, it impressed me that they were worthy of more discussion. The New Hampshire Medical Society is well advanced in the second century of its history. It has done its part well in advancing the science of medicine, and I trust that the years to come will be as fruitful as those of the past.

ANNIVERSARY CHAIRMAN.—Twenty-two years ago next September I went to Hanover to enter Dartmouth College. To me, then, it was the most beautiful place in the world. I will not attempt to describe my sensations as the old campus and its immediate surroundings appeared to my view from the top of one of Swasey's tally-hos. My class on entering numbered one hundred and two, a large class at that time, and there were not four hundred students in the whole institution, including the Medical College. That was the Old Dartmouth. To-day we have a New Dartmouth. During the last twenty years hundreds of thousands of dollars have been given the institution, and hundreds of thousands of

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dollars have been spent in the erection of new buildings and in other improvements, with everything up to date. Instruction at Dartmouth College has always kept pace with other advances. If a freshman twenty-two years ago experienced such sensations as I felt then, what must be the feelings of the young man who goes there as a freshman to-day? To what are we to attribute this remarkable growth? To my mind, it is due to the character and energy of its president, whose worth, recognized by all, has brought, and always will bring, the required support. Ladies and gentlemen, I have the pleasure and honor to introduce Rev. William Jewett Tucker, president of Dartmouth College.

DR. WILLIAM J. TUCKER.

DARTMOUTH COLLEGE.

Mr. President and Gentlemen:

I acknowledge the very great courtesy of your giving me a seat at your table to-night and also of your giving a place to the college by its representative at this social meeting of your Association. If I could take you to Hanover tonight, where the fellows are holding a *junior prom*, and where a comic opera is on, entitled "The Founders," I think you would get more instruction and entertainment in reference to the college than I can give you, and I doubt not if I were present there, I should learn some facts myself of which I am not now aware.

There are two thoughts about the relation of the college to the profession of medicine which I would like to refer to very briefly. The college was founded in 1769 and the medical school in 1796. I attribute the hospitality of Dartmouth College, as I have known it, to the scientific spirit, to the presence during that century of the medical department in the college. The medical men associated with Dartmouth College all through the nineteenth century were men who kept alive the scientific spirit and kept it in close touch with the humani-

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ties for which the college then stood; so that when the time came at the close of the century for the introduction on a large scale of the natural and physical sciences, the men of the college were prepared for it. I do not know of any college faculty which has met the transition so rapidly and easily from the old to the new, and I attribute the fact very largely to the presence in their body of so large a number of men who were intent on the science of medicine. The other fact is that during the vicissitudes which have attended the different professions, the number of men entering the profession of medicine from Dartmouth has remained almost a constant. Of course the powerful men of the early time were ministers, and all colleges were set toward producing powerful men. When politics came in, colleges turned in that direction, later toward the sciences, and now toward business. All the while the medical man as the product of the college has remained almost a constant. The ministry has declined, the law has declined, and teaching has declined; and there have been various changes, but the constant factor has been the medical man. I do not care to speak about the Dartmouth Medical School to a medical society, as you understand distinctly for what it stands.

I will speak in regard to a matter of which I think you in the profession of medicine, as those of us who are in the business of education, need to have a distinct thought. When one stands before a body of medical men, knowing the variety of topics of which you yourselves treat when you come together in convention, he feels almost in a state of bewilderment, like a boy dropped into a great city; or perhaps one feels somewhat in the frame of mind of the drunk who tumbled into a cab, and when the cabby asked "What street, sir," the man replied, "What street, what you got here for streets?" Your subjects are innumerable, so that one cannot miss his way if he takes his choice. I think, however, that if we are to classify professions, we can, among other ways, classify them in this way. There are professions which are to a certain extent independent of public opinion, and there

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are professions which must work with public opinion. I should say that the profession of arms was quite independent of public opinion; and to a certain extent the profession of law. When a man goes to war and when a man goes to court, he has to take things as they are. He understands quite well that he has to do with a certain compelling force, but when it comes to the profession of medicine, or of teaching, or of the ministry, there is a very much closer relation between these professions and public opinion. I recall the old Oxford story, as the question went round Dr. Jowett's table: Which has the greater power, the church or the law? One man said that the church was the stronger. A judge can say, "You be hanged," but a bishop can say, "You be damned." "Yes," said Dr. Jowett, "but when a judge says 'You be hanged,' you are hanged." That is one illustration of the difference between what I call the compelling professions and those professions which have a relation to public opinion. When I began my profession in Manchester, I lived in the home of Dr. Josiah Crosby. I was called upon to marry a couple who seemed to me to belong in the regular parish of the Rev. Dr. Wallace. I went to him and stated my sensitiveness on the subject. "Oh," said he, "Young man, you will find that people will be married and doctored and buried as they have a mind to be." There is, then, it seems to me, the very distinct relation of medicine, as well as of teaching and the ministry, to public opinion, and every profession that stands in that relation must see to it that public opinion is right. I believe, therefore, that every medical man must establish himself in absolute confidence in his relation to the public. Of course a large part of this is personal, but as things are to-day, confidence means respect, and respect means the sense which people who are dealt with have that they are efficiently dealt with. I was just speaking with our toastmaster, who remarked that in medicine it no longer made a difference whether a man was young or old if men really believed that he knew precisely what his business was. I think that this is true. The grounds of confidence

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are partly personal and partly professional, and if these are assured, the profession carries public opinion with it. I think it is true, too, that in your profession as in mine, and in some other professions, public opinion is shaped by the reasonableness of a profession. Is the profession arbitrary or rational in its judgments? Now a great many people with whom you come in contact are people of prejudice. They are people captured by a half-truth. The man who has a half-truth can go amongst them and win a hearing, but if you treat a man with a half-truth with contempt you will suffer. Anything against the established order comes, as a rule, out of confidence in the man who has a half-truth or a half-method. Probably there is nothing more remote from the established religious order than the Salvation Army, but it has a truth, the truth of authority, more, perhaps, than any organization whatever. It says to a man who has lost his will power, join the army. Let that furnish you with will power until you can regain your own. Of course the uniform and drum are nothing except for effect, but when a man is taken and put under orders and given days of self-denial and held in evidence until his will can regain its force, the power of the Salvation Army is evident. That is worth studying. The established order has studied it and is bringing back the element of authority into its own life. I say precisely so in reference to any profession where men are using a half-truth. Study it and bring it out.

One thing more. I believe that the medical profession gains upon public opinion; that it has gained upon public opinion in the last ten years and it is gaining every day through the courage of the profession. Medicine has been the commanding calling for the last ten or twenty years. There is no profession which has made such an advance, because there is none which dares to say bolder things to people or dares to tell them to do better things, and to do the things straight off. You are gaining the confidence of people and you are moulding public opinion by the position you are taking on various scientific and hygienic matters. By the posi-

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tion you are taking not only in what you do in your private practice, but in your public efforts, you are making people feel that the medical profession is moving on directly toward results. Indifferent it may be to fame, certainly indifferent to money, that fact is telling every day. I read in the Contemporary Review a few months ago, an article written by a London physician, in which he said that more advance has been made on the material side of medicine during the last ten years than on the spiritual side. Surgeonry had advanced, he claimed, more than anything else. If this is a just criticism, it is well for you to take it to heart. You have been making advances. Speaking as a layman, I say to you, keep on, but if necessary widen your course, as you belong to a non-compelling profession and, therefore, have to do with public opinion, see to it that you fulfill your great object by thoroughly educating the people, who are "our masters."

ANNIVERSARY CHAIRMAN.—We are fortunate in having with us to-night a gentleman from one of our neighboring states, and I am delighted to be able to present to you this evening Dr. Arthur W. Fairbanks, of Boston.

ARTHUR W. FAIRBANKS, M. D., BOSTON, MASS.

THE INSPIRATION OF MEDICAL MEETINGS.

Mr. Chairman, Ladies and Gentlemen:

When I saw my name so near the head of the list I thought that I should not have the opportunity to excuse my own deficiencies on the score of so many excellent speakers preceding me. It is always an advantage to be near the end of the list, as one can fall back on this old excuse. After hearing President Tucker's address, however, I have made up my mind that I can fall back on it now. I ought not to say anything to you after hearing that eloquent address. It seems to me that the advent of a stranger on an occasion like this is really an intrusion, and I should hesitate very much indeed to

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trespass on your social hour except for two reasons. The first is that I do not feel like a stranger, and I never have from the time when, as a boy, I came up into your granite hills and gained health that has lasted me ever since, to the present day. No one of your people has ever made me feel as a stranger, consequently I have not that excuse. The other reason why I wish to trespass on your time is because it gives me an opportunity before a representative gathering in the old Granite State to give expression from my heart of the affection I feel for this grand old commonwealth, a state where some of the happiest days of my life have been spent, a state, the very mention of the name of which brings back the kindest of friends and the most treasured of days. I should certainly trespass very greatly on your time if I attempted to give expression to my feelings, for my affection for New Hampshire is not second to that which I feel for my native state.

I want to say a few words on another subject, and that is the "Inspiration of Medical Meetings." Dr. Osler says, "No class of men needs friction so much as physicians; no class gets less. The daily round of a busy practitioner tends to develop an egoism of a most intense kind. The few set backs are forgotten, the mistakes are often buried and ten years of successful work tend to make a man touchy, dogmatic, intolerant of correction and abominably self-centred. To this mental attitude the medical society is the best corrective, and a man misses a good part of his education who does not get knocked about a bit by his colleagues in discussions and criticisms."

With this sentiment most of us will coincide. I think we will all agree that there is no vocation that is more capable of broadening the character of any man than that of medicine, and yet how often we find it to be otherwise. Now, I think that one explanation of this paradoxical condition of things is the fact that it is the easiest thing in the world to get out of the habit of attending medical meetings. When the time of the anticipated meeting arrives, the busy professional man

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says, "Oh, I don't believe I will go; it's going to take time, a whole day, possibly two days, and it is going to be pretty hard to arrange my affairs so as to get off. After all, what is the use. I can read the whole affair in my office when it is published, and without any trouble." So he stays at home. The next year it is all the more easy for him to remain away. Gentlemen, this poor colleague of ours, so fearful of losing time or money, could he but know it is in far greater danger, at the very moment when this thought comes to him, of losing something infinitely more precious than time or material possessions. He is about to lose his spirit, his ambition. This is the beginning of retrogression, of rust and of professional decay. In his college year, surrounded by other active and alert minds, he unconsciously absorbs enthusiasm and inspiration from the atmosphere in which he works and dwells. There are then moments while inspiration is at its highest, when, in spite of the technical difficulties with which the student finds himself confronted, glimpses of the real grandeur and nobleness of the work are revealed to him, but his degree obtained, he settles down in some quiet hamlet, or in some bustling, heedless city, and waits. In the first few years he meets certain of his professional brothers in a friendly way, then, as practice slowly comes, there not infrequently arises an alienation from his professional brethren, and differences, often on the most trivial foundations, occur; sometimes through busybodies among his patients who have more time to talk than to think. Soon this man finds himself alone and more or less isolated in his profession. Then comes, perhaps, the thought of rebellion from such narrow antipathies, a wider, broader horizon is dreamed of, and he intends to go to the society meeting and there breathe a clearer atmosphere. When the time comes, however, he allows some trivial reason to prevent the start, and he consoles himself again with the thought that he "can read it all at home," when the proceedings are published. He reads the account of the meeting perhaps, when it reaches him, and thinks that he has the gist of it all, when, poor fellow that he is, he does not realize that he has, indeed,

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received the body, but not the soul. He has lost all the precious feeling of comradeship in his life-chosen profession which such meetings inspire and which alone can keep his heart and soul alive. He has lost the salutary benefit of attrition with other minds, has missed the opportunity of frankly expressing his views on the daily problems that confront him and having those ideas severely, though friendly, criticized. He has missed the very essence of the gathering—friendship, inspiration and courteous toleration of another's views—and yet this misguided one is still our brother.

To how many of us at one time or another has not the thought come that we "could read it all in the paper" after the fashion of personally conducted travels abroad by way of a thick volume consumed by the fireside at home.

Last summer I went out to Portland, Ore., to the meeting of the American Medical Association, and while there I missed in the meetings the face of a friend and colleague of mine who lives in Seattle, only one night's ride from Portland. On my way home I stopped in Seattle and called on this friend, chided him for his absence and asked him the reason. He said, "Oh, I was chasing the dollars."

Now, gentlemen, I cannot but think what a contrast this is to the spirit shown by John Rogers, when in 1791 he traveled from Plymouth to Exeter, on horseback, through the wilderness, to attend the first meeting of this society, one hundred and fifteen years ago. He was a son of New Hampshire, and a worthy son, and a worthy representative of the best of the medical profession to-day. If he accomplished nothing else in his life, the inheritance that he has left us, the inspiration of his example alone would be a most precious heritage.

I wish to close my remarks by echoing the words of a former president of yours, echoing but with added emphasis of my own: There is no danger of saying too much in honor of the medical profession of New Hampshire in its relation to any department of life, civically, socially, professionally; it has been tried by the severest tests from its earliest history to the present day, and has never been found wanting

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when duty called, as staunch and sturdy and as true as the granite foundation of the state itself.

ANNIVERSARY CHAIRMAN.—The subject of the next sentiment is "The Physician as a Financier." The gentleman who will respond to this toast, I know very well. I have fished with him, and I once tried to sleep in the same bed with him. I think he is well qualified to speak on this particular subject. He owns an automobile. He has owned more than one automobile. Any man who can own more than one automobile and not "go broke" must be a good financier. One day, about a year ago, about the noon hour, this man, in response to my inquiry as to how his machine was working, said, "Oh, slick." He then went on to tell me how he had been to Portland about a week before to have some part repaired, how it took him a whole day in Portland, costing him between thirty and forty dollars for the repairs, and that about half-way home this same part broke down and was in the same condition as it was before repair. He said, "I made up my mind right there that I would get acquainted with that machine, so after I got it home I took it out in my stable floor and I took it all to pieces. I took off every nut and took out every screw and bolt and laid them down so I would know just where they belonged. I cleaned her all up and then I put her together again, and I've never seen her run so smooth as she has since I fixed her." About three o'clock that same afternoon one of our local truckmen had this "fixed" machine in tow, hauling it to the doctor's house. I said to the doctor that evening, "Doctor, I thought you told me that you had fixed that machine." He replied, "I did, but the d—d thing would n't stay fixed." Ladies and gentlemen, it affords me great pleasure to introduce Dr. John H. Neal.

JOHN H. NEAL, M. D.

Mr. Toastmaster, Ladies and Gentlemen:

My position to-night appears to me very much like that of the darkey boy who was the thirteenth offspring of his

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parents. A gentleman became interested in the family, having seen the father and the mother and all of the thirteen children together, and was questioning the father as to his family. He asked if all were his children, to which he answered "Yes." He says, "This is the youngest, I take it." "Yes, sir, he is." The gentleman said, "What's this little fellow's name, he appears to be a bright boy?" The darkey replied, "His name is Judas Iscariot." "This is infamous! It is scandalous! What in the name of heaven did you ever name this boy Judas Iscariot for?" The darkey replied, "You see the good book says that it would have been better for Judas Iscariot if he had never been born. We thought this was a very appropriate name for this boy, as it would have been better for him and for the rest of the family had he never been born." I now feel it would have been better for me had I not been present to-night. As far as you are concerned, I am sure it would have been better for you if I had been called to a case of diarrhœa, cystirrhœa, gastrorrhœa, blennorrhœa or some other orrhœa, ere I had forced myself upon your ear this evening, but I know the disposition of the New Hampshire Medical Society, I know of its indulgence, and shall for a short time indulge in that indulgence.

The sentiment to which your toastmaster has asked me to respond is one which under no circumstances should ever be discussed by medical men. It is entirely inappropriate for this occasion, and any man who ever had any idea concerning the natural order of things, would have never asked another to respond to any such sentiment on such an occasion as this.

This sentiment could not be discussed by men who are dealing with physical laws, as physicians are to a very great extent. There is no place on earth in which, nor any body before which, this question could be discussed excepting a body of Christian Scientists, because the physician as a financier exists in the mind and in the mind only.

Were it possible for any one of us to capture and cage the first physician whom we should find to be a financier, we

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should have one of the greatest assets which was ever possessed by any living person, because we should have a greater unnatural living curiosity than was ever presented to the American public. If we could preserve this monstrosity alive, the exhibition of him for a short time would produce all the wealth which any one man could reasonably desire, but the diet of the physician would not be congenial to this modern financier, and the best the physician could do would not in all probability be sufficient to support him. Even, I believe, if dead, we should still have a great asset, if exhibited. I hear some one say that he has known a physician who was a financier, and that my statement is consequently too strong. When you find a physician who is a financier, he is not a physician, he is a financier. The two are incompatible. The condition reminds me of a story which Mark Twain told concerning himself in regard to the first poetry he ever wrote. He said he wrote it and sent it to the magazine man for publication. He watched issue after issue for his poetry, he did not see it. Finally he wrote the magazine man asking if his poetry had been published, and if so in what issue of the magazine, and if not, why not. He said he got back a letter from the magazine man stating that he (the magazine man) did not know who he was, that he might be a fool, but certainly he was no poet and that was the reason why his poetry had not been published.

The toastmaster alluded to the fact that I have owned one or more automobiles, and has insinuated that because a man has owned more than one automobile that he must of necessity be a financier. Now he, the same as physicians ordinarily do in regard to financial questions, has taken hold of the wrong end of the question, and to illustrate I will relate to you a story:

A lady whom I know very well is a lover of dogs; her husband is very wealthy. She was out on the lawn one day and had three dogs with her. A gentleman who knew her very well as he was passing said, "Good morning, Mrs. G., those three dogs yours?" She said, "Yes, sir." "Well,"

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he said, "that certainly is the limit. Anybody can own one dog, if he is poor he can own two, and if he is damned poor he can own three or more." Now with slight variations I will make the application: Almost anybody can own one automobile, if he wants to be poor he can own two, and if he is determined to be damned poor he can own two or more.

Some time ago a gentleman came into my office, and as he did so noticed an inscription on my door which has been there for years. It reads like this: "All persons with schemes will please keep out. I have some of my own to promote." After reading it and coming in, he said, "Halloo, Doc, I see you have been pinched some time. That little writing on your door is a dead giveaway." I acknowledged that he had diagnosed the case correctly. He assured me that he at least came to me with the real article. He had a proposition on the ground floor, the ground floor was a section of mother earth, or a portion of mother earth as nature had left it, in the same county in which a mine exists, from which a few have taken thousands and the many have invested millions in excavating the hole.

I presume there is no class of men which furnishes more lambs than the medical profession. The aggregate wealth which they invest is not so much as the aggregate wealth of some other classes of men, but like the widow of ancient history, they put in their all and keep repeating the operation and keep looking in one hole in the ground after another for that which they have deposited in previous excavations, and keep on making excavations and looking for the wealth which they have previously deposited and which they believe to be located somewhere, until finally each monopolizes a hole in the ground, six feet more or less, due east and west, and about six feet perpendicular.

There is another illustration to which I will refer with reference to the financiering of physicians. The insurance companies of this country, which have accumulated enormous wealth through the skill and caution of physicians, when they are called to task by the American people for their mis-

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conduct and squandering of money, commence retrenchment and reform, and one of the places where they save is in cutting down the fees of physicians forty per cent., and then we generally acquiesce in their own courteous language by subscribing our names to cards or letters which they themselves have formulated, and we have done this in the face and eyes of the fact that this medical society, an organization of physicians, antedates any and every trust which has been formed in this country. But we have reason to be thankful that we are not modern financiers, for the financiering of this country has received the condemnation of the American people. It is a monstrosity of unnatural growth, and the financier of the future will resemble the financier of the past in name only, like the game of football, compared with which a prize fight is a gentlemanly diversion. The financier of the future will be of legitimate growth, and we as physicians have every reason to be thankful that we were not placed in the same channels in which some of the financiers of this country were placed, for we should have developed into what they have developed. Some of them have already died of remorse, which the medical profession with all its skill was unable to check, and they have left stigmata upon their names which will be handed down to their posterity, even to the third and fourth generations. But the physician's line of development has been natural. For this we cannot boast, but have reason to be thankful. Natural development has made us what we are. Unnatural development could have made us financiers, and we have no reason to boast of any special virtues but have cause to be thankful for our environments. To illustrate this I will relate a story, which runs as follows:

A physician who had practiced many years was approaching the end. The spirit was just about to leave the body. An angel met this spirit and was about to escort it into the celestial city. As the doctor was passing he noticed an open door through which he saw a multitude of people, and he asked the angel what the gathering of people meant. The answer was, "That is Hades. Would you like to look in for a short

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time?" The doctor replied that he would. The angel ushered him in and told him that he must leave for a short time as he had duties of a similar character to perform for others, but that he would return and meet him again. Evidently that season was more unhealthy than the present one. When the angel returned the doctor was sitting in an arm chair in front of a fireplace fanning himself, and with a very pleasant smile upon his countenance. The angel said to the doctor, "Why do you smile?" The doctor answered, "Do you see those ingrates and delinquents right there? Do you see them in that fire? This is heaven enough for me. I would like to be left right here."

ANNIVERSARY CHAIRMAN.—One of the most prominent men in the state of Kansas was one day discussing religion in his office, and he made a statement as to the great piety of the people in general of that state. To prove his point, he turned to a small boy who had entered. "Johnny," asked the gentleman, "What is your pa's religion?" "Well," said the boy, "he thinks he 's a Presbyterian—but he aint working at it much." Perhaps I may be anticipating some of the remarks of the gentleman who is to follow, but it strikes me that this story is apropos to physicians as a class in so far as it applies to church attendance.

Ladies and gentlemen, it gives me great pleasure to introduce the Rt. Rev. Edward M. Parker, D. D.

THE RT. REV. EDWARD M. PARKER, D. D.

THE MEDICAL PROFESSION FROM A CLERGYMAN'S STANDPOINT.

Some years ago, while taking a railroad journey to Boston, I met in the car Governor Rollins and four or five other men who were very gorgeously dressed in military uniform. I chaffed one or two of them on the extreme brilliancy of their appearance, when the governor said to me, "Come along and I will appoint you on my staff." He was going down to an Old Home celebration, and I went along with him. My

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family have got thoroughly tired of my referring to the proud time when for thirty-six hours I was a colonel, and I rather think they will get equally tired of my reference to the time when, by virtue of this badge, I was for twenty-four hours a member of the New Hampshire Medical Society.

There has been no provision made on the programme for to-morrow for any narration of my medical experiences. I listened with great interest to the papers this morning, as they dealt largely with facts. Now I want to tell you the facts of *my* medical experience, for perhaps they may be of some practical use to some of you! A good many times I have been in charge of houses with a few boys in them, or with a considerable number of boys, and oftentimes those boys fell ill with one trouble and another. First, I talked to them cheerfully. (I believe that is all right according to the modern medical theories.) Second, I got in a trained nurse or somebody who had professional knowledge, which I also believe is all right. Third, I brought out a set of mustard leaves that I always kept on hand and I put one of those mustard plasters on some part of the boy's anatomy, and it always worked well for three reasons. In the first place, it occasionally did him a little good; secondly, it could not possibly do him any harm; and thirdly, he very soon began to think he was being really treated!

I have been asked to speak to the toast of the medical profession from a clergyman's standpoint. By the "medical profession," I suppose it means the physicians themselves. There are three things which occur to me, which I may say represent the standpoint of the clergy—the way in which the clergy look at the medical profession. In the first place, I think we honestly look with the greatest admiration, and with the greatest envy in a certain way, at the continued and persistent self-denial of medical men. A great many of the clergy work very hard, but after all we get our nights in bed for the most part, and I am sure that we should feel that we were very badly used if two or three nights a week in succession we were called up when we had just fallen comfortably to sleep after a hard day's work, to go out and do something for some of

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our fellows, and that is what you gentlemen of the medical profession are doing. Self-denying work for others is one of the things of which we think when we think of the doctors. The other day I had to drive ten miles out at night, and I was obliged to drive ten miles back afterward. It was not a very good night. I put up my horse and then got to bed, and I thought I was doing pretty well. But I had a talk with the doctor friend with whom I took supper, and when I asked him something about the condition of the roads, he told me that he had driven fifty or sixty miles a day all through mud-time. My twenty miles looked pretty small to me then! (I spoke of this to one of my friends in the city of Boston the other day and she asked me what happened to the doctor's poor horse!) The second thing of which we think when we speak of the medical profession is this, that you look at the clergy with a good deal of suspicion, and that you really are not quite fair to us. The other day in talking with a doctor in Massachusetts, he told me that the last thing he thought of doing was to call in a clergyman or allow him to go near the patient, as it would frighten him to death, and make him think he was going to die at once; in fact, a certain medical school teaches, he said, that it is a part of the duty of the doctor to keep the parsons away from the patients. Now there are all sorts and kinds of parsons—parsons of various degrees of knowledge, of tact, and of experience—but I may tell you that sometimes we look at you doctors, and we think that you are not quite fair to us, and we feel that somehow or other you ought to work a little more with us, in helping *us* to help sick people. I know you may not agree with me there. You are thinking of specific cases where it would have worked all sorts of harm and made all sorts of trouble. We are separated a good deal. You look on us with a good deal of suspicion. As a clergyman I ask what can you do with regard to this difficulty? I think there are two ways in which this thing from our standpoint is not as it should be, in which you can help us to remedy it. In the first place, I think you can try to get to know us better and to let us get to know you better. There is a friend of mine

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in Boston who is a physician, and who in talking about this matter to some of his fellows said: "You know I know quite a lot of clergymen, and they are very good fellows really. They are very nice. You ought to get to know them. You would not be so much afraid of them." But I think the attitude of the medical profession is a little bit like that of another friend of mine. I was going to make a round of pastoral visits in a new section—some visits to get acquainted with people. A man was told that "the minister was coming to see him." This man used to work in a furniture shop and there was one machine that "the men were all afraid of," which was a moulding machine. They "never could tell just exactly what it was going to do," and this man felt much the same way about the minister who was coming to see him!

Now if, before sickness and troubles come, you would give us a chance to know you better, and if you get to know us better, we could work in sympathy together. Further, I think you can help us by *teaching* us. You will find that parsons do not mind plain talk, and plain advice, about things. Tell us how we ought to behave in the sick room. Give advice to young men who are beginning their careers, to make their visits short, so as not to tire out the patient. Tell them this thing, or that thing, which your own experience and your own good sense will suggest, and you will find that we are grateful to you for such assistance. I shall never forget the immense impression that I made on one family because I knew enough to turn the patient's pillow over, beat it up a little, and then place it back. They thought I was a wonder of medical knowledge!

Now we are not going to tread on your toes in the way of trying to practice medicine, but you can help us, and you can remove this grievance, which, from a clerical point of view, is one of the ways in which we look at the medical profession. Talk plainly to us and give us practical advice as to how to behave in a sick room.

How do we look at the medical profession? I will tell you one of the things we look at. We look with envy at the way

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in which you get at the facts of people's lives and the way in which you get at people, and the absence of sham and putting on, which exists in your dealings with them. People sometimes try to put on airs with us of the ministry a good deal, and they make an intelligent man very mad by acting as if they thought this and that course of behavior would impress one with anything except disgust. I always feel like saying, "Do you think I am such a fool as to be taken in by that kind of thing?" *You* get right at facts, and you get right at things as they *are*. You have opportunities for doing a great deal of good in a community, which we of the clergy can get in no such direct way. Take the great question of the relation of the sexes, of purity, and of moral habits of one sort and another, questions which are so difficult to handle, and so difficult to approach in a way that will be helpful. You, gentlemen, have opportunities which we of the clergy get slowly, and get with infinite pain, and get less easily, and less obviously, and less directly, than you do. You can help people in that way, whom we of the clergy can never touch; and if you will remember your opportunities, you can do a grand moral work in the way or through the means which your own good sense suggests, in the case of young girls for example. By direct, forceful speaking to young men, by plain instruction to boys, you have opportunities, if you will only use them, which we of the clergy look at with envy, and with the earnest desire that we might be put in your place in that respect.

ANNIVERSARY CHAIRMAN.—We have with us a gentleman who has very kindly come on from New York, and I am happy to be able to present Dr. Robert H. McConnell, of New York City.

ROBERT H. MCCONNELL, M. D.

THE WORK AMONG CHILDREN IN NEW YORK.

Ladies and Gentlemen:

After listening to the speeches to-night, I feel rather like a very old patient whom I had some years ago. He was an

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Irishman by the name of Finnigan. He had the unfortunate habit of drinking too much, and many a time I was called to go over and straighten him out. Each time Finnigan would promise me that he would not touch another drop, but after two or three days he was as bad as ever. Finally, I told him that if he did not stop drinking I would have to stop going to see him. At last he agreed to take only one glass of whiskey a day, but within four or five days I was again called and found him in the usual condition. On the following day, when he was sober, I asked him why he had broken his promise. He told me the trouble was, that two or three friends came in that night and he told them that he could drink only one glass of whiskey a day; that he had taken one glass for that day, then one for the day after, and finally he got into the middle of the next week, when he did n't know where he was. Now that is the way I feel to-night after listening to the speeches.

I am very much interested in the work among children. If I tell you a little bit as to how it is accomplished, perhaps it may be of interest to you. The particular place in which I am working is connected with the College of Physicians and Surgeons in New York City. We have several thousand cases a year coming for treatment. They come all the way from two weeks up to fourteen years. I think the very small children are the particularly interesting ones, and it has been stated that just as soon as a hospital or college or any other institution gets little children among them that particular institution will succeed. When these small children are brought in, a very careful history is taken from the time they are born. Every possible thing that can be thought of and any little point in their history has special attention. After that has been taken, they are weighed and measured, and a thorough physical examination is made, and any particular points are gone into very thoroughly. If they are feeding cases, and those are the most interesting ones because that is a part of medicine which has not been settled yet, the doctor who has charge of the room in which the child is assigned, makes a

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certain formula which is given in printed form to the mothers, and the child is sent away to return in two days' time. At the end of two days the child is brought back, and if the formula agrees with the child, it is told to come back. If the formulas do not agree at the end of a week's time, some change is either made in their feeding or else the case is referred to the head doctor for advice. The older children are taken care of in about the same way, printed instructions being given to the mothers, and the mothers in that way have learned a very great deal regarding the character and feeding of infants. It is surprising how much tenement-house women know about taking care of babies. I heard two Irish women one day discussing the dose of antitoxin, and only by means of the clinics and dispensaries has their knowledge been brought up to the extent which it has. There are other colleges and clinics in New York which have done the same good work. A great many of the students connected with the college are employed during the summer months to visit these children. The institute which is endowed by Mr. John D. Rockfeller for research in medical science, particularly in children, has done a great deal of good. Mr. Nathan Strauss has placed in various parts of the city depots where sterilized milk can be obtained for practically nothing, and in that way poor people in tenement-houses are able to get their milk and proper formulas for feeding.

Now the growth of pediatrics in New York lately has been very rapid. It was in 1860 that Dr. Abraham Jacobi was made a professor of pediatrics in the New York Medical College. He was the first professor of that particular subject in this country. At that time it was not made a separate study. It was only after a good many years hard work on the part of Dr. Jacobi that the study was taken up as a separate branch of medicine. It was in 1898 that a ward was put in Roosevelt Hospital for the bedside instruction of students in pediatrics, the first one of its kind in the country. It was called the Jacobi ward. Now nearly all hospitals have special wards for children with special attending physicians. We have

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one large hospital entirely devoted to babies under three years of age. Nurses are not allowed to graduate from hospitals unless they have had a special course in the care of children, and the doctor who doesn't know something about infant feeding is lost if he attempts practice in the city. There are a great many of the younger men taking up the specialty of pediatrics, and there are some lively meetings at the pediatric section in the Academy of Medicine. There is one thing about a doctor looking after children. Each doctor knows more than the other one about the care of infant feeding. The result is, when we have meetings there are some very sharp discussions, and I think these discussions make good meetings. I believe the more discussion there is the more we learn. I do not believe the reading of a paper is half the value of the discussion.

I want to thank the gentlemen of the New Hampshire Medical Society for the very courteous way in which I have been treated since I have been here. I came here practically an absolute stranger, but I feel like an old friend, and if any of you come to New York, I will do my best to make it pleasant for you, as you have for me.

ANNIVERSARY CHAIRMAN.—We have present to-night a delegate from the Vermont Medical Society. I met the gentleman a few moments before coming into the banquet hall, and while he did not refuse to say anything, yet hoped that I would not feel obliged to call on him, but I think you would all like to hear from him. With pleasure I introduce Dr. F. Thomas Kidder, of Woodstock, Vt.

DR. F. THOMAS KIDDER.

Gentlemen of the New Hampshire Medical Society:

When I received the notice from the Vermont Society that I was elected a delegate to this Society, I was pleased and gratified. I live so near to the New Hampshire line that I know very many of your members, and I took occasion to say to one of them, who is a good friend of mine and well known

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[illegible] that I might come to [illegible] meeting. He [illegible] to do so and at the same time cast some aspersions [illegible] Society. He said that if I would go [illegible] I would find out what a medical society meeting [illegible] was. In Vermont the doctors all went to the bar [illegible] meetings and not to the medical society. Possibly [illegible] statement may be true. I came to Concord [illegible] to find out what a medical society meeting is about. [illegible] did not know before. I came here in a very unassuming way, as a countryman might, was introduced to the audience and made a little speech of a few words as the occasion demanded, and supposed that was all that was required of me. I looked at the banquet and found there was more that I was expected to do. As I came into the hall here the toastmaster said he would like to call on me, and of course I could not refuse to do so, but absolutely refuse to speak, after all the courtesy that had been shown me. I also had a very high compliment paid me. Dr. Conn, who is sitting opposite me, was told by some one who I was, and he very kindly told me that I was the Rev. Mr. Parker. I wish to thank you for your courtesies, and would like to give you a little advice. Doctors, go to your society meetings, attend the banquets, unless you are fond of making speeches, do not accept complimentary tickets.

Vice-Chairman Chairman.—This concludes the speaking [illegible] evening, and I wish to thank the gentlemen who have [illegible] spoken. I now bid you all good night.

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by you all, that I might come to this meeting. He urged me to do so and at the same time cast some aspersions on my own Society. He said that if I would go down to Concord I would find out what a medical society meeting was like; that in Vermont the doctors all went to the health officers' meetings and not to the medical society. Possibly part of his statement may be true. I came to Concord and I have found out what a medical society meeting is, allowing that I did not know before. I came here in a very unsuspecting way, as a countryman might, was introduced to the Society, made a little speech of a few words as the occasion demanded, and supposed that was all that was required of me. I came to the banquet and found there was more that I was expected to do. As I came into the hall here the toastmaster said he would like to call on me, and of course I could not be discourteous and absolutely refuse to speak, after all the courtesy that had been shown me. I also had a very high compliment paid me. Dr. Conn, who is sitting opposite me, was asked by some one who I was, and he very kindly told them that was the Rev. Mr. Parker. I wish to thank you for all your courtesies, and would like to give you a little advice, and that is, go to your society meetings, attend the banquets, but unless you are fond of making speeches, do not accept a complimentary ticket.

ANNIVERSARY CHAIRMAN.—This concludes the speaking of the evening, and I wish to thank the gentlemen who have so kindly spoken. I now bid you all good night.

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FRANK W. BLAIR, M. D.

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OBITUARIES.

FRANK W. BLAIR, M. D.

Dr. F. W. Blair, of Farmington, died in Portsmouth, November 19, 1905, of cancer of the stomach.

Dr. Blair was the son of Capt. and Mrs. B. F. Blair, of Boothbay Harbor, Me., where he was born February 13, 1875. He was graduated from the Boothbay Harbor high school in 1891, Bowdoin College in 1895, and from the Bowdoin Medical School in 1898.

In college he was a member of Psi Upsilon Fraternity, and in the medical school, of Alpha Kappa Kappa.

During his college and medical school days he was principal of Boothbay Harbor high school, and also Blue Hill Academy.

After graduating from the medical school he did hospital work in New York for awhile, and then came to Farmington to assume the practice of Dr. Parker. There he was enjoying a good practice and was loved and esteemed by all.

He was married June 27, of last year, to Mary Eveleth Weeks, of Bath, Me.

Dr. Blair was prominent in Masonic circles, being a member of the Knights Templar.

He leaves, besides his newly married bride, a father and mother, and brother, Dr. George K. Blair, of Salem, Mass.

JOHN H. SANBORN, M. D.

John H. Sanborn, M. D., one of the best known physicians in the state, died at his home in Franklin, December 19, 1905.

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He was born in Meredith, September 23, 1830, the son of Dr. John and Susan Hubbard Sanborn. He began the study of medicine with his father in Meredith, and studied also with his brother, Dr. J. A. Sanborn, of Plymouth, and with Prof. B. R. Palmer, of Vermont Medical College, of Woodstock, Vt. He was a graduate from the Berkshire Medical Institute at Pittsfield, Mass., November 23, 1852. He practiced his profession in Alstead until December, 1855, and in Meredith until he enlisted as surgeon in the Twelfth New Hampshire Volunteers. He was present at the battles of Fredericksburg, Gettysburg, Drury's Bluff, siege of Petersburg and Cold Harbor, but was on detached service from January to July 14, 1863, at the brigade hospital at Falmouth, Va.

After the war he resumed his practice in his native town for several years, and then removed to Franklin, where he soon established an enviable reputation and became well known as one of the best read physicians of the old school, and a prominent citizen. He was a member of the State Medical Society, and was at one time president of the Cenrte District Medical Society. He never was an office-seeker, but was always a stanch Republican, and took an active part in things political. He served as a member of the board of education under the town government. He was prominent in Masonic orders, and for many years took a leading part in the degree work of Meridian Lodge. He had an excellent memory and a ready wit, and won wide repute as a story teller.

Dr. Sanborn married Elizabeth H., daughter of the Rev. Giles Leach, May 16, 1854. Of his four children only one is living, Mrs. Harriet L., wife of Edgar A. Jones, of this city.

WALTER K. WADLEIGH, M. D.

Dr. Walter K. Wadleigh, of Hopkinton, died February 7, 1906, of disease of the kidneys, after a severe illness of several weeks.

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JULIA WALLACE-RUSSELL, M. D.

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Dr. Wadleigh was the son of Jonathan Taylor Wadleigh and Betsey Thomas, and was born in Franklin, April 7, 1865. He attended the schools of his native town, and in early manhood began the study of medicine with Dr. Luther Knight, and later with Dr. Sleeper, of Franklin. He received the degree of M. D. at Dartmouth Medical College, and began the practice of his profession at Hopkinton in the year 1887. He was above the average in ability, and was genial and pleasant in his social relations, which gave him the respect of the community and a good practice among the best citizens of the town.

He was the soul of honor in his relations with his brother physicians, and enjoyed their confidence and respect. Dr. Wadleigh was never married.

JULIA WALLACE-RUSSELL, M. D.

After a brief and baffling illness, Dr. Julia Wallace-Russell, who had the distinction of being one of the first and most successful women physicians in the state, died July 1, 1906.

Dr. Russell was born in Hill, N. H., March 24, 1844, the daughter of Edmund and Mary Johnson Wallace, and was the widow of the late Waldo P. Russell. She is survived by two daughters and a sister, Dr. Ellen A. Wallace, of Manchester. She was a graduate of the Woman's Medical College of New York Infirmary in 1877, and spent one year in the New England Hospital for Women and Children, at Boston.

The death of Dr. Julia Wallace-Russell is a distinct loss to her profession and a loss to the community. She was at her death the foremost woman physician in New Hampshire; in fact, such had been her position for many years. She was a leader in her profession, wise, tactful and firm, and few citizens there are who had her acquaintance and confidence but will deplore her death.

Dr. Russell possessed marked characteristics. She had a stout courage combined with a clear knowledge or intuition

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of what could be done in advancing the cause of her profession. She was given wide and unusual experience in her practice, which extended throughout the state, and she had long been accorded a high recognition among the profession, and held in deep affection and respect by those whose sufferings she had relieved. But Dr. Russell was more than a practicing physician, she was a builder whose works remain after their founder has passed away. Concord will always associate her with the Memorial Hospital for Women and Children, the creature of her ambition and steadfast perseverance.

Impressed by experience and association that a woman's hospital ought to have a place in New Hampshire, she resolutely set about the almost hopeless work of establishing such an institution. In 1896 success had met her efforts. It is as the founder and manager of the Woman's Hospital that Dr. Wallace-Russell will be remembered. Her life's work was such that few persons, laymen or professional, can hope to accomplish, and she was happy in the reflection that her life had been spared to see the institution for which she had labored so long and so successfully, firmly established. She began practice in Concord in 1878, and, in this city, she spent her entire professional life. Her standing was at once conceded, and she became not only one of the first women physicians in the state, but one of the first women to be admitted to the New Hampshire Medical Society. Dr. Russell's activities were not confined to her profession. They extended into social relations as well. She manifested a lively interest in Concord affairs, and cheerfully co-operated in promoting worthy causes. "If she had done nothing more than to found the Woman's Hospital, her coming would have been a welcome addition to the citizenship of Concord, but her private benefactions have kept pace with her public work, and she has given cheer to many a household. Her successful practice and teachings for the benefit of her sex have placed her as a leader among the medical profession." The state has lost a patriotic daughter, the city a devoted servant.

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EUGENE F. MCQUESTEN, M. D.

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EUGENE F. McQUESTEN, M. D.

Dr. E. F. McQuesten died July 18, 1906, at Squirrel Island, Me., whither he had gone in the hope of recovering his health,

Dr. McQuesten was a native of Litchfield, where he was born on October 11, 1842, the son of Isaac and Margaret Ann (Chase) McQuesten. The family, which has resided in Litchfield since 1735, is of Scotch-Irish origin, the pioneer ancestor being William McQuesten, who came from the north of Ireland.

Dr. McQuesten received his early education in the public schools of Nashua, being graduated from the high school in 1860. He attended Blanchard Academy, Pembroke, two years, and then entered the scientific department of Dartmouth College. Two years later he began the study of medicine with Dr. Josiah G. Graves, of Nashua.

He attended a course of lectures at Dartmouth and two courses at the Jefferson Medical College, receiving the degree of M. D. at the latter institution on March 10, 1866. In 1872 and 1892 he took full lecture courses at the Jefferson College. After a few months practice in Lynn, Mass., he began his Nashua practice on January 1, 1867.

The extensive learning, conspicuous ability and high social standing of the physician made him the logical incumbent of many offices, and he was for years one of the most widely known physicians in the state. For years he figured as an expert witness in nearly all the important criminal and accident cases in the state.

He was city physician in 1871–72, representative to the legislature from Ward 2 in 1873–74, and secretary of the board of pension examiners from 1893–97.

Dr. McQuesten was especially noted as a surgeon, and was frequently called to perform difficult operations in all sections of New Hampshire and Massachusetts. He was a member of the American Medical Association, the American Association of Railway Surgeons, and the New Hampshire

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Medical Society, of which he was president in 1895. He was also a member of the New York Medico-Legal Society. Politically, Dr. McQuesten was a Democrat, and at times took an active interest in public affairs, but never to such an extent as to interfere with his business.

He was a member of the several Masonic bodies up to and including the Knights Templar, and was a member of the Mystic Shrine.

Dr. McQuesten amassed considerable wealth, and was interested in a number of financial enterprises. He was a director in the Nashua Trust Company, and resigned at the time of the troubles consequent upon the Goggin irregularities.

Dr. McQuesten was three times married. His first wife was Lizzie M. Spaulding, daughter of Samuel Spaulding, of Nashua, who died in 1877, after being his wife nine years. In 1879 he married Mary A. Howard, of Nashua, who died in 1885, and in May, 1887, he married Anna E. Spaulding, daughter of William R. Spaulding, of Lawrence, Mass.

Besides his wife and children, Dr. McQuesten is survived by a brother, Frank McQuesten, of Lawrence, Mass., and a sister, Mrs. Frederick Center, of Litchfield.

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ANNUAL MEETING, 1906.

LIST OF THE MEMBERS OF THE NEW HAMPSHIRE MEDICAL SOCIETY.

N. B. *The secretary requests members to examine this list closely*, and notify him of any corrections to be made, as it is intended to publish the list annually, and it is desirable to make it as accurate as possible. *Members allowing themselves to become three years in arrears for dues will find their names dropped from the roll, as it is construed that they no longer desire to remain connected with the Society.* Members are not entitled to a copy of the Transactions until their dues are paid to the treasurer. An asterisk (*) indicates a retired member.

Members will please remember that it will facilitate the work of the secretary, and ensure their receiving all communications from the Society, if they will at once notify him of any change of location and address.

Admitted.	Name.	Residence.
1872.	Abbott, A. W.	Laconia.
1894.	Abbott, Clifton S.	Laconia.
1900.	Abbott, George F.	Littleton.
1899.	Abbott, W. H.	Hillsborough Bridge.
1894.	Adams, Chancey	Concord.
1873.	Adams, D. S.	Manchester.
1904.	Aldrich, E. B.	Manchester.
1906.	Aldrich, Lewis C.	Whitefield.
1888.	Aldrich, W. H.	Marlborough.
1886.	Allen, Bradford	Nashua.
1878.	*Allen, Carl A.	Holyoke, Mass.

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Admitted.	Name.	Residence.
1890.	Allen, C. J. . . .	38 Church St., Winchester, Mass.
1886.	Allen, George E. . .	Bradford, Mass.
1901.	Allen, Walter A. . .	Hampstead.
1894.	Annable, Edwin G. .	Concord.
1876.	Anthoine, I. G. . .	Nashua.
1889.	Atherton, Ella Blaylock	Nashua.
1898.	Axtell, John F. . .	Newton.
1902.	Bakeman, Francis A. .	Franklin.
1896.	Baketel, H. S. . .	123 Gifford Ave., Jersey City, N. J.
1904.	Baketel, Roy V. . .	Manchester.
1882.	Bancroft, Charles P. .	Concord.
1902.	Barker, Ralph H. . .	Chester.
1894.	Bartlett, Clarence S. .	Gardner, Mass.
1885.	Bean, J. W. . . .	West Medford, Mass.
1898.	Beaton, Alexander A. .	Franklin Falls.
1900.	Beattie, William J. .	Littleton.
1898.	Beauclerk, W. P. . .	Concord.
1903.	Beckford, Henry S. .	Belmont.
1898.	Bell, Ernest L. . .	Plymouth.
1886.	Berry, John J. . .	Portsmouth.
1878.	Blaisdell, Frank . .	Goffstown.
1869.	Blaisdell, George C. .	Contoocook.
1905.	Blanchard, Roscoe G. .	Dover.
1897.	Bogardus, Frank A. .	Canaan.
1879.	Boutwell, Henry T. .	Manchester.
1883.	Boutwell, Henry W. .	Manchester.
1904.	Brady, William Alva .	841 No. Broad St., Philadelphia.
1888.	Brigham, Frank E. .	Salmon Falls.
1897.	Brown, Elmer F. . .	Groveton.
1865.	Brown, J. Frank . .	Manchester.
1871.	Brown, J. P. . . .	Taunton, Mass.
1898.	Brown, James S. . .	Manchester.
1900.	Brownrigg, Albert E. .	Nashua.

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Admitted.	Name.	Residence.
1856.	Burnham, Hosea B.	Manchester.
1894.	*Burnham, John L.	Las Cruces, New Mexico.
1884.	Burns, Robert	100 Valentine St., West Newton, Mass.
1906.	Butterfield, Clarence E.	Suncook.
1893.	Buzzell, C. P.	Conway.
1906.	Carleton, Elmer H.	Hanover.
1899.	Carpenter, Harry B.	Lancaster.
1892.	Carpenter, Irving L.	Manchester.
1902.	Carr, Burt W.	Pittsfield.
1879.	Carvelle, H. D. W.	Manchester.
1902.	Charest, Joseph A.	Nashua.
1902.	Charest, J. Charles B.	Greenville.
1891.	Cheney, Jona. M.	Ashland.
1883.	Chesley, A. P.	Concord.
1903.	Chesley, Alice M. M.	Exeter.
1905.	Chesley, Harry O.	Dover.
1867.	Child, William	Highland Springs, Va., and Piermont, N. H.
1906.	Childs, Alfred H.	Dublin.
1899.	Claggett, F. P.	Newport.
1892.	Clark, Edgar A.	Concord.
1906.	Clarke, George H.	Concord.
1897.	Cobb, J. J.	Berlin.
1876.	Cogswell, J. R.	Warner.
1902.	Cogswell, Samuel J.	Derry.
1897.	Cole, C. I.	Henniker.
1902.	Congdon, Charles E.	Nashua.
1865.	Conn, G. P.	Concord.
1899.	Cook, Charles H.	Concord.
1869.	Cook, George	Concord.
1905.	Cooke, T. Bates	Laconia.
1902.	Coolidge, John W.	Bristol.
1898.	Cotton, C. B.	Wolfeborough.
1897.	Craig, James A.	Westmoreland.
1900.	Crosby, Walter T.	Manchester.

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Admitted.	Name.	Residence.
1897.	Crossman, E. O.	Lisbon.
1903.	Cummings, Frederick R.	Concord.
1882.	Currier, E. H.	Manchester.
1873.	Currier, D. M.	Newport.
1897.	Cutler, Charles H.	Peterborough.
1873.	Cutler, George I.	West Swanzey.
1878.	Danforth, M. S.	Manchester.
1897.	Davenport, George E.	Bath.
1890.	Davis, George M.	Manchester.
1901.	Davis, W. S.	Sanbornville.
1890.	Day, Arthur K.	Concord.
1899.	Day, H. C.	Exeter.
1895.	Dean, E. E.	Lebanon.
1876.	Dearborn, D. S.	Milford.
1906.	Dearborn, Edmund C.	Keene.
1899.	Dearborn, Samuel S.	Nashua.
1899.	Dillon, R. H.	Manchester.
1869.	Dinsmoor, S. M.	Keene.
1878.	Dodge, C. M.	Manchester.
1902.	Dolloff, Albert S.	New Hampton.
1905.	Dolloff, Charles H.	Concord.
1896.	Dougherty, Thomas J.	Somersworth.
1899.	Douglas, O. B.	Concord.
1905.	Downing, Arthur T.	East Barrington.
1883.	Drake, C. B.	West Lebanon.
1905.	Drake, Dean S.	White River Junction, Vt.
1897.	Drake, E. T.	Franklin.
1904.	Drew, John A.	Rumney.
1897.	Dunbar, E. B.	Manchester.
1905.	Duncan, Charles	Concord.
1897.	Eastman, Charles A.	476 Massachusetts Ave., Cambridge, Mass.
1904.	Eastman, Eugene B.	Portsmouth.
1883.	Eastman, O. D.	Woodsville.
1906.	Easton, Frank Birch	Laconia.

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Admitted.	Name.	Residence.
1879.	Eaton, Frank . . .	East Weare.
1889.	Erskine, James B. .	Tilton.
1900.	Evans, F. W. . .	Coös.
1878.	Fairbanks, C. A. . .	Dover.
1890.	Faulkner, H. K. . .	Keene.
1900.	Ferguson, Samuel T. .	North Weare.
1901.	Fernald, Arthur M. .	Sutton.
1902.	Fernald, Fred . .	Nottingham.
1906.	Finerty, Joseph W. .	Milford.
1883.	Fisher, E. C. . .	Sunapee.
1883.	Fisher, F. P. . . .	Enfield Center.
1901.	Fiske, George V. . .	Northwood Ridge.
1883.	Flanders, Charles F. .	Manchester.
1896.	Flanders, Louis W. .	Dover.
1896.	Flanders, M. E. M. .	Hopkinton.
1895.	Fontaine, Henri T. .	Sanatorium, Pembroke.
1902.	Foster, Avery Moulton .	Candia.
1868.	Foster, T. S. . .	Laconia.
1897.	Fowler, Isaac N. . .	Lebanon.
1885.	French, Edward . .	Harding, Mass.
1875.	French, L. M. . .	Manchester.
1893.	Fritz, Emdon . .	Manchester.
1893.	Frost, Gilman D. . .	Hanover.
1899.	Gallinger, Ralph E. .	Concord.
1887.	Garland, William R. .	Plymouth.
1897.	George, Arthur Phillips.	Haverhill, Mass.
1882.	George, Charles F. .	Goffstown.
1901.	Getchell, Stillman P. .	Wolfeborough.
1881.	Gibson, Charles R. .	Woodsville.
1898.	Gibson, J. M. . .	McIndoes Falls, Vt.
1898.	Gile, John M. . .	Hanover.
1899.	Gilman, Charles S. .	Warren Chambers, 419 Boylston St., Boston, Mass.
1902.	Gilman, Louis L. . .	Rochester.

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Admitted.	Name.	Residence.
1896.	Gleason, John H.	Manchester.
1865.	Goodhue, D. P.	West Springfield.
1885.	Gould, Charles R.	Tilton.
1883.	Gove, George S.	Whitefield.
1897.	Grafton, F. W.	Concord.
1904.	Grant, Albert E.	Durham.
1883.	Grant, L. E.	Somersworth.
1869.	Graves, E. E.	Penacook.
1905.	Graves, Robert J.	Concord.
1890.	Gray, George H.	Lynn, Mass.
1893.	Greeley, Guy H.	Merrimack.
1893.	Greeley, James T.	Nashua.
1901.	Greeley, Philip H.	Farmington.
1903.	Griffin, Nathan L.	Bradford.
1894.	Grimes, Warren P.	Hillsborough Bridge.
1897.	Guertin, Augustus	Nashua.
1897.	Guillet, Noel E.	Manchester.
1892.	Guptil, George H.	Raymond.
1901.	Hale, William	90 Washington St., Gloucester, Mass.
1882.	Hammond, C. B.	Nashua.
1904.	Hanaford, Howard A.	Newport.
1904.	Hannaford, Charles W.	Portsmouth.
1863.	Hanson, C. W.	Northwood Ridge.
1899.	Hart, M. A. H.	Milton.
1888.	Harriman, A. H.	Laconia.
1900.	Harrington, Charles W.	Peterborough.
1902.	Haskell, Pearl T.	Concord.
1880.	Hatch, G. W.	East Wilton.
1888.	Hawkins, F. L.	Meredith.
1880.	Hawley, George H.	Barnstead.
1887.	Hayes, John A.	Somersworth.
1895.	Hazard, George S.	Hollis.
1885.	Hazelton, George W.	Haverhill.
1893.	Heffenger, Arthur C.	Portsmouth.
1886.	Hiland, Thomas	Grafton, Mass.

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Admitted.	Name.	Residence.
1899.	Hildreth, H. A.	Bethlehem.
1894.	Hill, Edmund E.	Suncook.
1896.	Hill, Gardner C.	Keene.
1890.	Hill, Roscoe	Epsom.
1896.	Hilliard, William A.	Westerly, R. I.
1897.	Hills, Frederick L.	Concord.
1905.	Hoag, Albert B.	Center Sandwich.
1892.	Hodgdon, E. P.	Lakeport.
1900.	Hodsdon, B. Franklin	Manchester.
1888.	Hodsdon, E. W.	Centreville.
1902.	Hoitt, George B.	Manchester.
1872.	Holbrook, Guy	22 Central St., Lowell, Mass.
1885.	Holbrook, Henry C.	Penacook.
1888.	Holcomb, C. H.	Brookline.
1906.	Horne, B. Frank	Conway.
1886.	Houghton, E. F.	Tilton.
1891.	Hoyt, J. Elizabeth	Concord.
	Huckins, John C.	Ashland.
1903.	Huckins, Theron H.	Tilton.
1889.	Hummiston, F. G.	East Jaffrey.
1882.	Hutchinson, H. S.	Milford.
1890.	Hyland, Jesse B.	Keene.
1892.	Ingalls, George H.	Jamaica Plain, Mass.
1884.	Jarvis, Leonard	Claremont.
1898.	Johnson, H. L.	Franconia.
1899.	Johnston, Charles E.	9 Federal St., Brunswick, Me.
1899.	Jones, Edwin E.	Colebrook.
1883.	Jones, F. P.	Mill Village.
1887.	Jones, Fred W.	New Ipswich.
1897.	Jones, S. W.	Franklin Falls.
1891.	Kean, M. E.	Manchester.
1904.	Keay, Forrest L.	Rochester.
1905.	Keene, Lenwood M.	Kittery Point, Me.

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Admitted.	Name.	Residence.
1904.	Kenniston, William B.	Exeter.
1886.	Kimball, George M.	Concord.
1860.	*Kingsbury, C. F.	West Medford, Mass.
1898.	Kingsford, H. N.	Hanover.
1890.	Kittredge, Frank E.	Nashua.
1897.	Knapp, Lee V.	Danbury.
1905.	Knowlton, John G. W.	Exeter.
1906.	Lacasse, Leon Joseph	Manchester.
1906.	Ladd, Elmer E.	West Rumney.
1893.	Lake, E. E.	Hampstead.
1898.	Lamb, Frank W.	32 Rockliff St., Portland, Me.
1892.	Lamson, Charles A.	Elkins.
1902.	Lance, Arthur J.	Portsmouth.
1882.	Lanouette, Joseph E. A.	Manchester.
1876.	Lathrop, M. C.	Dover.
1898.	Lavallee, Arthur M.	Suncook.
1903.	Lawrence, William E.	North Haverhill.
1884.	Leet, George E.	Concord.
1891.	Leet, James A.	Enfield.
1889.	Leith, William H.	Lancaster.
1885.	Lemaitre, Joseph E.	Manchester.
1904.	Little, Charles S.	Laconia.
1895.	Littlefield, Anna M.	New London.
1902.	Locke, Eva M.	Nashua.
1887.	Lougee, George W.	Freedom.
1906.	Lovejoy, Frank H.	Milford.
1901.	Lovering, Frank S.	Moultonborough.
1899.	Luce, Thomas W.	Portsmouth.
1891.	Lyons, William H. A.	Manchester.
1899.	Macleay, A. Alexander	Manchester.
1854.	*Manahan, Val.	Enfield.
1895.	Marden, A. S.	Newport.
1901.	McGahan, Charles F.	Bethlehem.
1888.	McGregor, G. W.	Littleton.

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Admitted.	Name.	Residence.
1897.	McLaughlin, Frank W. .	West Stewartstown.
1892.	McMurphy, Nelson W. .	Gilmanton.
1868.	†McQuesten, E. F. . .	Nashua.
1887.	Megrath, William A. .	Loudon.
1888.	Merrill, J. F. . .	Warner.
1904.	Miller, Elmer M. . .	Woodsville.
1903.	Miliken, Clarence W. .	Manchester.
1892.	Mitchell, Abram W. .	Epping.
1882.	Mitchell, Ezra . .	Lancaster.
1895.	Mitchell, William Henry	Loudon.
1883.	Moran, B. G. . .	Nashua.
1891.	Morey, G. B. . .	Manchester.
1892.	Morgan, George P. .	Dover.
1882.	Morse, Charles A. . .	Newmarket.
1893.	Morrill, Leonard B. .	Center Harbor.
1898.	Morrill, Sibley G. . .	Concord.
1906.	Morrison, George H. .	Whitefield.
1883.	Munsey, G. F. . .	Suncook.
1899.	Murray, John T. . .	Manchester.
1897.	Mygatt, Harry E. . .	149 Main St., Nashua.
1892.	Nason, Inez H. . .	Dover.
1898.	Neal, John H. . .	Rochester.
1897.	Newcomb, Vesley M. .	Somersworth.
1905.	Newell, Harry W. .	West Derry.
1873.	Nicols, C. B. . .	719 Grant Bld'g, Los Angeles, Cal.
1881.	Nute, W. H. . . .	Exeter.
1897.	Nutter, Charles F. . .	Nashua.
1905.	Ober, Charles F. . .	Manchester.
1883.	O'Brion, C. C. . .	Groveton.
1868.	Odell, J. W. . . .	Greenland.
1900.	Oliver, Robert F. . .	Alstead.
1901.	Osterhout, John J. .	Marlow.
1881.	Otis, E. O. . . .	381 Beacon St., Boston, Mass.

† Died since the meeting.

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Admitted.	Name.	Residence.
1874.	Palmer, Haven	Plymouth.
1905.	Parker, David W.	Manchester.
1896.	Parker, George H.	Wells River, Vt.
1885.	Parker, H. R.	Dover.
1868.	Parsons, John W.	Portsmouth.
1880.	Pattee, W. H.	Manchester.
1897.	Patterson, Charles F.	Rye.
1895.	Pease, Byron D.	Greenville.
1879.	Perkins, F. B.	West Derry.
1901.	Perkins, Frederick	Manchester.
1889.	Petit, A. Wilfred	Nashua.
1884.	Pettingill, James B.	Amherst.
1897.	Phipps, A. G.	Gorham.
1893.	Pitman, Arthur J.	Candia.
1906.	Pratte, Arthur A.	Keene.
1900.	Pratt, Harry S.	Bethlehem.
1880.	Pray, J. W.	East Northwood.
1903.	Proctor, John D.	Keene.
1883.	Prouty, Ira J.	Keene.
1904.	Provost, A. M. J.	Berlin.
1894.	Quackenbos, John D.	331 W. 28th St., New York.
1900.	Quinn, Charles H.	West Concord.
1894.	Reed, Elizabeth B.	Keene.
1890.	Richmond, Allen P.	Dover.
1857.	*Roberts, S. W.	Wakefield.
1887.	Robinson, John F.	Manchester.
1901.	Rogers, Charles C.	Farmington.
1904.	Rowe, Walter C.	Andover.
1878.	†Russell, J. Wallace	Concord.
1888.	Saltmarsh, George H.	Lakeport.
1884.	*Sanborn, C. A.	Redlands, Cal.
1880.	Sanborn, G. H.	Henniker.
1902.	Sanders, Henry C., Jr.	Claremont.
1900.	Sanders, Loren A.	Concord.

† Died since the meeting.

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Admitted.	Name.	Residence.
1887.	Scott, N. H.	Wolfeborough.
1890.	Shea, A. W.	Nashua.
1881.	Shedd, George H.	North Conway.
1901.	Shedd, John Z.	North Conway.
1897.	Sikorsky, Vladimir N.	Salem.
1888.	Smith, A. Noel	Dover.
1893.	Smith, Frank A.	Lebanon.
1899.	Smith, H. L.	Nashua.
1888.	Smith, Henry O.	Hudson.
1902.	Smith, Wm. Eugene	Franklin Falls.
1879.	Smith, W. T.	Hanover.
1888.	*Spaulding, F. W.	Clifton Springs, N. Y.
1897.	Sprague, E. G.	Barre, Vt.
1892.	Stackpole, H. H.	Dover.
1882.	Staples, J. W.	Franklin Falls.
1897.	Stark, Gillis	West Manchester.
1899.	Stearns, Henry C.	Haverhill.
1891.	Steele, Minot A.	Portsmouth, R. I.
1902.	Stewartson, Charlotte D.	Manchester.
1895.	Stickney, H. L.	Manchester.
1875.	Stillings, F. A.	Concord.
1890.	Stokes, D. L.	Rochester.
1880.	Stone, M. T.	Troy.
1891.	Straw, Amos G.	Manchester.
1892.	Straw, Zatae Longsdorff	Manchester.
1876.	Sturtevant, C. B.	Manchester.
1891.	Sullivan, D. E.	Concord.
1905.	Sullivan, Miah B.	Dover.
1903.	Sumner, Arthur F.	Concord.
1892.	Sweeney, Henry L.	Kingston.
1894.	Swett, Eddy B.	Grasmere.
1898.	Sylvian, Emil A.	Manchester.
1886.	*Taft, A. H.	Winchester.
1898.	Taft, E. H.	Milford.
1903.	Talbot, Bertell L.	Peterborough.
1905.	Tarbell, Wallace H.	Bedford.

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Admitted.	Name.	Residence.
1905.	Taylor, Herbert L.	Portsmouth.
1897.	Taylor, Joseph	313 Granite St., West Manchester.
1897.	Theriault, Joseph	Concord.
1903.	Thompson, Edward H.	Wolfeborough.
1906.	Thompson, Wellington A.	Manchester.
1893.	*Thurber, M. T.	95 Savin Hill Ave., Boston, Mass.
1897.	Tobel, Frederick Von	Lebanon.
1902.	Togus, Theodore M.	Hooksett.
1877.	Tolles, C. W.	Claremont.
1904.	Tolman, George A.	Dover.
1895.	Towle, Fred S.	Portsmouth.
1890.	Towle, G. H.	Deerfield.
1878.	Towne, G. D.	Manchester.
1904.	Toye, J. E.	Acworth.
1904.	True, Walter H.	Laconia.
1874.	Tucker, E. M.	Canaan.
1904.	Tuttle, Walter	Exeter.
1902.	Underwood, David G.	Bradford.
1898.	Varick, William R.	Concord.
1880.	Wade, E. A.	Salem Depot.
1878.	Walker, C. R.	Concord.
1901.	Walker, Charles S.	Keene.
1904.	Walker, Wallis D.	Portsmouth.
1893.	Wallace, Alonzo S.	Nashua.
1904.	Wallace, Arthur L.	Nashua.
1886.	Wallace, Ellen A.	Manchester.
1904.	Warner, Franklin G.	Antrim.
1894.	Wason, Eugene	Milford.
1860.	*Waterhouse, William	Barrington.
1885.	Watson, George M.	Manchester.
1879.	Watson, I. A.	Concord.
1901.	Watson, Maurice	Manchester.
1887.	Way, Osman B.	Claremont.

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Admitted.	Name.	Residence.
1883.	Weaver, C. A.	New Boston.
1899.	Weaver, George A.	Warren.
1904.	Webber, Norman B.	Manchester.
1905.	Weeks, R. William	Manchester.
1898.	Wellner, Herman	1619 Garfield Boulevard, Chicago, Ill.
1882.	Weymouth, G. W.	Lyme.
1845.	*Weymouth, H. A.	Andover.
1894.	Wheat, Arthur F.	Manchester.
1906.	Wheatley, Hannibal P.	Farmington.
1899.	Wheeler, John	Plymouth.
1905.	Whitcomb, Chas. S. F.	Contoocook.
1902.	Wilder, Richard E.	Whitefield.
1903.	Wilkins, George C.	Manchester.
1896.	Wilkins, Russell	Concord.
1902.	Woodbury, F. T.	Wakefield, Mass.
1904.	Woodman, James B.	Franklin Falls.
1889.	Woodman, M. S.	West Lebanon.
1883.	Woodward, J. N.	Nashua.
1904.	Work, Manly W.	Bennington.
1904.	Worthen, E. M.	Ashland.
1879.	Young, Leander J.	Haverhill, Mass.
1905.	Young, John	Farmington.
1896.	Young, Oscar C.	Charlestown.

HONORARY MEMBERS.

1903. Barnard, H. E., B. S., Indianapolis, Ind.
1898. Bartlett, Edwin J., M. D., Hanover.
1887. Billings, John S., M. D., New York.
1900. Cheever, David W., M. D., Boston.
1900. Coit, J. Milnor, Ph. D., Concord.
1900. Cumston, Charles G., M. D., Boston.
1900. Gay, George W., M. D., Boston.
1900. Richardson, Maurice H., M. D., Boston.
1906. Williamson, W. D., Portland, Me.

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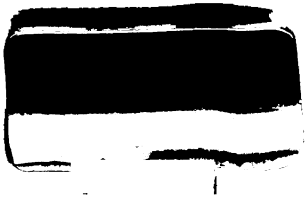

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